MULTIDISCIPLINARY CARE IN PSYCHIATRY: HISTORY, CHALLENGE AND ANALYSIS FOR IMPROVEMENT

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ABSTRACT

Psychiatric illnesses take place in the context of socioeconomic circumstances. A growing body of evidences support that a multidisciplinary care system that includes not only medical management but also social and psychological care significantly improves short-term and long-term outcomes of diseases. However, at the current stage, multidisciplinary teams often function without an exact manual and would rely on traditions and previous customs that vary among centers, which can make individual professionals involved in the care to feel uncertain and ambiguous in terms of his or her roles. This can pose a serious a risk of professional frustration and sense of disempowerment, which can negatively impact team dynamic and quality of patient care. This article attempts to articulate possible challenges that can be faced by multidisciplinary team, and how such challenges can be addressed and handled. To achieve this, first, elements of multidisciplinary care model will be identified, and roles of each professional member will be delineated. Then, challenges that can be faced by a multidisciplinary team will be addressed, using a historical example of National Institute of Mental Health (1946) and a personal account from a British social worker. Then, possible solutions for the current problems will be discussed, which include implementing effective communication systems and adapting a multidisciplinary care plan to address the special needs of different age groups. In closing, I will emphasize that multidisciplinary care is both a medical and ethical imperative; not only sociobehavioral interventions will improve patient adherence, prevent relapse, and maximize the effect of

the care, but also the model will facilitate patient's recovery of agency, the ability to discern right from wrong, and autonomy, the right to make the decision that is most consistent with their beliefs and value systems.

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CHAPTER 1: ELEMENTS OF MULTIDISCIPLINARY PSYCHIATRIC CARE

Psychiatric illnesses, as they concern mood, cognition, and human behaviors, are closely linked not only to the biological and genetic makeup of a patient, but also to social and behavioral factors. To address this complexity, current psychiatry encompasses a wide range of clinical practices, from medical assessment and pharmacotherapy to psychoeducation, occupational skills training and many other social and community interventions. Occupations in mental healthcare include, but are not limited to, mental health counselors, clinical psychologists and neuropsychologists, psychiatrists, social workers, social and community service managers, nurse practitioners and registered nurses, occupational therapists, and psychosocial rehabilitation workers (Liberman et al., 2001).

The benefits of addressing a mental illness in such multidisciplinary ways are well-articulated. When social approaches such as cognitive behavioral therapy, social work and community programs were incorporated into psychiatric care, they help patients articulate challenges, understand their illness, and take a proactive role in the treatment process (Liberman et al., 2001). Effective social approaches help foster a sense of rapport and trust between clinicians and patients, encouraging patient adherence to the treatment plan (Roncaglia, 2016).

At the same time, having to work out a coordinated, multidisciplinary care plan can be a daunting task for practitioners. Tasks of different experts may overlap, and responsibilities are shared often in an arbitary way. While a degree of flexibility may

allow opportunities to customize the care for each patient, it also has a potential risk of causing confusion among the experts. Especially when it comes to care coordination, unclear definitions of role may lead to confusion in professional identity and occupational dissatisfaction (Roncaglia, 2016).

In addition, establishing communication systems is another huge task. A multidisciplinary team needs to ensure that the flow of information happens in a timely manner and that any concerns and opposing ideas can be openly addressed among members. Inadequate communication systems may not only lead to conflicts within the team but also significantly lower the quality of the care (Roncaglia, 2016).

Thus, in this paper, I will explore how challenges that are be faced by multidisciplinary team can be addressed and handled. To achieve this, I will first define a multidisciplinary care model by identifying elements and delineating roles of each professional member. Then, I will summarize the benefits of a multidisciplinary care model and articulate challenges that can be faced by a multidisciplinary team. I conclude by presenting possible solutions to improve the current system.

Elements of Multidisciplinary Psychiatric Care

The term multidisciplinary care is used in a broad sense, without a set manual or rule that defines its size, composition or structures. Before starting the discussion, I would like to first describe each profession's expertise and responsibilities.

Medically trained personnel include psychiatrists, nurses, clinical pharmacists, and physician's assistant. Psychiatrists may take a leading position in a multidisciplinary

team. They make clinical diagnosis, monitor psychopathology and psychopharmacology, and make a medical intervention in cases of crisis (Liberman et al., 2001). They may also conduct cognitive behavioral therapy or assertive community treatment with adequate training. Nurses and physician's assistants also make important medical decision, and often have frequent and persistent interactions with patient. Thus, they may exert an important influence in encouraging patient adherence and collaboration in the treatment process (Chien et al., 2013). Furthermore, experienced nurses help recognize side effects of medication and catch important physical signs in a timely manner (Liberman et al., 2001).

Psychologists are experts trained in psychoanalysis with a post-graduate degree. Tasks of psychologists include patient and family psychoeducation, structured interventions with families, skills training, cognitive-behavioral therapy, and motivational interviewing (Liberman et al., 2001). They can diagnose and monitor psychopathology. They usually do not perform pharmacotherapy, but in five states, which are Iowa, Idaho, Illinois, New Mexico, and Louisiana, appropriately trained psychologists can prescribe medications. They collaborate with social workers and case managers to address patient's social and financial need.

Occupations that addresses social and community services include social workers, rehabilitation counselors, occupational therapist, case managers, family advocate, employment coach and many other possible positions. Social workers are informed with available community resources, thus work to meet economic needs of the family and help patients obtain housing and financial entitlements (Liberman et al., 2001). They also take

part in assertive community treatment and family education (Liberman et al., 2001). Rehabilitation counselors and occupational therapists support patient during the recovery phase of disabling illnesses. They perform functional assessment and provide skills training and motivational interviewing (Liberman et al., 2001). Case managers work to connect clinical cases to community-based services, such as entitlements and other needed services (Liberman et al., 2001). Family advocates enhance cultural competence of the team, so that the team can individualize care to each patient's case. Employment specialist and job coach assist patient to recover social function by supporting employment process.

Psychosocial Supplement to Medical Therapy: Practical Applications and Effectiveness

In a multidisciplinary team, the main treatment of choice is pharmacology and medical intervention led by psychiatrists. This evidence-based intervention addresses neurobiological and genetic causes of disorders during acute and stabilization process. To maximize the efficacy of treatment and encourage patient adherence, a multidisciplinary team further provides psychosocial supports in multiple layers.

Psychoeducation of patients and families is an important element. A patient may receive medical treatment to control biological causes of an illness, but in mental disorders such as mood disorders, psychosis, suicide, and substance use disorder, there is a high risk of relapse and recurrence. Oftentimes, social and behavioral factors prevent patients from adhering to the treatment regimen, and there are countless examples that

proves this. To illustrate few, approximately one-third of patients with bipolar disorder takes less than half of their medication, which result in increased rates of suicide and hospitalization (Machado-Vieira et al., 2004). In cases of substance abuse, the social and economic stress factors such as debt, stress, and unemployment may promote initiation of usage and work against cessation (Griffin and Botvin, 2010).

To address such social and behavioral causes, methods such as cognitive-behavioral therapy, dialectical behavioral therapy and focus groups are employed to guide patients handle with stress-inducing events, set personally relevant life goals, work with family and other supporters, and develop a social support model for themselves (Liberman et al., 2001). These interventions encourage patient adherence and compliance to the treatment (Machado-Vieira et al., 2004). Clinical researches have proven that psychosocial education improves symptom control, relapse rate, and level of functioning, and promotes greater stability in a long-term (Kopelowicz et al., 2006).

Social and occupational skills training are important during the stabilization and rehabilitation phase. After suffering from disabling conditions, a patient may need to receive skills training to recover social and occupational function (Liberman et al., 2001). Social skills sessions focus on developing family relations, recreation, housing, conversation, friendship, and intimacy (Liberman et al., 2001). Successful social skills training not only lead to successful community life of patient, but also improve patient self-confidence, empowerment, optimism, and mood, which serve as protective factors in refractory mental illnesses such as schizophrenia (Kopelowicz et al., 2006). Adequate

social skills may compensate for cognitive deficits and neurobiological vulnerability (Kopelowicz et al., 2006). Researches have proven that good psychosocial functioning leads to high levels of patient life satisfaction, improves adherence to treatment, and promotes recovery (Kopelowicz et al., 2006).

During the stable phase of a disorder, occupational therapists assist with occupational training, job finding and supported employment services (Tsang and Pearson, 2001). Supported employment is an evidence-based treatment for vocational rehabilitation for people who have suffered from severe mental illnesses (Herz et al., 2000). Without adequate supporting program, about a half of individuals with mental illnesses placed in competitive jobs would lose the job in 6 months (Diamond et al., 1991). Programs, such as The Workplace Fundamentals Module, have been devised to improve the job tenure, success, and satisfaction of mentally ill people by teaching them how to "anticipate job stressors, utilize stress management techniques, identify and overcome stigmatizing attitudes, solicit performance feedback and assistance from one's supervisor or employer, and start conversations and relationships with coworkers" (Diamond et al., 1991). Studies showed that such employment support programs increase job satisfaction and improve tenure after getting jobs (Diamond et al., 1991).

In addition to occupational training, community work may support patient financially by giving adequate entitlement to patients and connecting them to available community resources. Social workers and case managers help patients determine or gain

eligibility to federal programs such as the Social Security Disability Insurance Program and the Supplemental Security Income program (Danziger et al., 2009). A persistent mental illness is related to reduced work activity and lower earnings; these social support programs assist patient reenter the society as a labor force (Chien et al., 2013).

A multidisciplinary approach is proven to be effective in various disorders including mood disorders, schizophrenia, substance abuse and many others. There hasn't been a comparative study that investigated whether any single approach is better than other (Chien et al., 2013); However, since each approach covers different aspect of an illness, in most cases, they will need to be flexibly combined to address complex nature of the illness.

Multidisciplinary Care in Practice: A Historical Case

While numerous researches report benefits and effectiveness of multidisciplinary care, there are also practical challenges that are often overlooked or neglected. To best illustrate this, I would like to introduce a historical example where challenges were observed and documented in a multidisciplinary care setting.

One of the earliest attempts in the US to form a multidisciplinary mental health team took place in 1960s. During this period, the need for public mental healthcare centers were on the rise. The Second World War exerted undeniable influence over the American society. The rate of mental health disorders sharply increased, most notably

post-war PTSD patients both in soldier groups and civilians who faced high level of stress (Jackson, 2013). The asylum population in the United States increased to 500,000 by 1946, and the number of hospital-admitted psychiatric patient reached 1 million in the US military (Grinker and Spiegel, 1945).

The government soon initiated series of plans that accommodated establishment of community centers, with objectives of reducing the incidence, duration and severity of mental disorders, and minimizing impairment caused by developed disorders. The National Mental Health Act in 1946 led to the establishment of the National Institute of Mental Health (NIMH) in 1949, and the Mental Health Study Act in 1955 led to the foundation of the Joint Commission on Mental Illness and Health (JCMIH), also known as the Joint Commission on the Mental Health of Children (JCMHC or CMHC).

These centers were established with the aim of accommodating populations who are now deinstitutionalized, and help them recover in their own community. In attempt to achieve this, the center was structured in a way that involved paraprofessionals familiar with local culture. For example, a center would recruit a wide range of professionals including psychiatrists, nurses, social workers and community mental health workers (Smith, 2007).

However, a conflict among professionals developed soon after the establishment. A series of correspondences in science journals of the period reveals this conflict. In the case of the CMHC, a clear delineation about how responsibility is shared among different positions were insufficient, which lead to professionals doubting paraprofessional’s role and capability. Psychiatrists of the period criticized the paraprofessionals for lacking

“formal education.” (Smith, 2007). A social worker Emmanel Hallowitz further criticized that professionals who received a training with local culture would better understand and address issues seen in the community than the nonprofessionals with lesser degree of education could do (Hallowitz and Reissman, 1967). Hallowitz harshly criticized that the assumption that “the poor” have “special knowledge and insight” that are not available to “the affluent” is simply wrong (Hallowitz and Reissman, 1967). Certified mental health professionals were reluctant to share responsibility with uncertified paraprofessional, whom they considered did not have capacity to make a clinical decision (Hallowitz and Reissman, 1967). On the other hand, paraprofessionals would argue that they are the ones who knew “what was really going on”.

A lack of coordination produced unnecessary tension among team members, creating unproductive and stressful work environment. A survey in 1987 reveals a high rate of burnout among psychiatrists working in the CMHC, and demonstrates that the main reason why psychiatrist left the center was because they were uncertain about their role and value in the center (Vaccaro and Clark, 1987).

At present, the case of CMHC is viewed as a mixed success, as it came to the end without producing remarkable success. Adding to the internal conflict were financial strains that the CMHC faced. In the 1970s, the Vietnam War and the resignation of President Johnson significantly reduced funding on community mental health policies. The centers could not accommodate a large number of mental health patients who were now deinstitutionalized from Asylums, leading to many mentally ill patients ending up in prisons and becoming homeless (Smith, 2007).

Multidisciplinary Care at the Present: Challenges, Analysis and Solutions

In the healthcare scene at the present, similar issues are observed. When people from different expertise and experience work together, a clear description and delineation of the role and responsibility is essential to avoid confusion and conflict. In often cases, however, a multidisciplinary team would function without an exact manual; instead, they would rely on traditions and previous customs that vary among centers.

In *Maintaining identity*, an anonymous article written by a British social worker, introduces this issue from a first-person perspective. Anonymously written by an experienced social worker, the article shows how a multidisciplinary team without structure can be confusing for an individual and thus have a risk of being counter-productive. The author herself had an opportunity to build professional identity before joining the multidisciplinary team because she worked for many years in a generic social work team. However, the author describes and empathizes with confusion of her student, who was receiving her first professional training in a multidisciplinary team without previous experience as a social worker. The student was losing her confidence as she was uncertain about the core social work tasks, for example how the tasks of a social worker differ from those of a mental health nurse. The author admits that the tasks of social workers are now shared with nurses, occupational therapists, and even clinical psychologists, thus it can be difficult for social workers to “hang on to” their professional identity. The author concludes the writing by stating that there is a need to provide

support and definition for social workers working in multidisciplinary mental health settings, so that social workers can understand “what they are actually for.”

Such unclarity in roles is noted as a significant risk factor for a multidisciplinary team. In the article *A Practitioner’s Perspective of Multidisciplinary Teams: Analysis of Potential Barriers and Key Factors for Success*, the author notes that confusion in professional identity may lead not only to conflict among the team members, but also mistrust from patients that may significantly lower the quality of care (Roncaglia, 2016). This reflects the CMHC case, where the undefined professional roles were resulted in criticism and mistrust among professionals. Most importantly, unresolved misunderstanding led to underproductivity, higher rate of dissatisfaction and professional burnout (Vaccaro and Clark, 1987).

These cases demonstrate a possible need for a science-based, systematic approach in which professionals can form a clear expectation about their roles within the team. A research team in California, in their effort to articulate the elements of successful multidisciplinary team in psychiatric rehabilitation, points out that, in addition to the science-based practice of each expert, the team itself needs an evidence-based manual (Liberman et al., 2001). In psychiatry, practitioners tend to consciously and subconsciously apply their personal and professional experiences during the decision-making process. While this may help intrinsically understand the cases, it does not negate the need for an evidence-based, rather than experience-based, team structure. As demonstrated early in this section, ambiguity in roles poses a risk of professional

frustration and sense of disempowerment, which may be detrimental to team dynamic and effective patient care.

To this date, there are several evidence-based programs designed for multidisciplinary teams with specific purposes. To name few examples, there are dialectical behavior therapy for borderline personality disorder (Linehan, 1993), integrated programs for clients with a dual diagnosis of a psychiatric disorder and a substance use disorder (Ho et al., 1999), the Program for Assertive Community Treatment (PACT) (Stein and Santos, 1998), and individual placement and support for supported employment (Phillips et al., 2001). These programs specify which professionals to be included in the team and roles of each team member. Furthermore, they provide guidelines about how information and opinion are to be shared among team members, for example through computerized system and regular team meetings. As the manuals describe in detail how each expert may contribute to a team, it facilitates coordinated interventions. Considering established programs like these can be one solution that an emerging multidisciplinary team can take advantage of.

The second element required in the multidisciplinary team is a purposeful and timely communication. Missed clinical information may result in clinical misdiagnosis or mistreatment that could have been otherwise avoidable. It is important that obtained patient information is shared among professionals in adequate and timely manner. Furthermore, experts may have different clinical philosophy and may have different approaches to an illness. Thus, it is important to create a setting where disagreement can

be discussed openly. Misunderstanding and discordance among team members may significantly lower the quality of clinical decision and patient care. Most importantly, when a patient gets a conflicting message, mistrust of medical professionals may ensue, which can be detrimental to patient adherence to the treatment.

The author of *A Practitioner's Perspective* emphasizes the role of communication in the multidisciplinary team. A successful communication helps the team form a clear, well-defined, shared goal, thus help foster a sense of collective commitment. Communication helps the team clarify each member's role, set clear values and aim, build trust and tolerance, and allow constructive feedback. Adequate communication increase knowledge and confidence of team members (Roncaglia, 2016).

To this date, researchers have identified elements of successful team communication that can be applied to practice. First, the size of the team is important. The size between eight and twelve members are considered ideal; if the team is too big, it is difficult that every member engage in discussion which may slow down the dynamics of the team (Miller et al., 2005). Also, it is important to clearly define what type of information is to be shared, with who and what time frame, so that members can expect what information they need to gather and share (Roncaglia, 2016). To ensure timely communication, cell phone, e-mail, weekly meetings and daily briefings can be used (Liberman et al., 2001). A focus group interview conducted by UK team found that clinicians found face-to-face regular meetings to be more helpful than a computerized data system, because talking in person allowed immediate feedback, and rationales

behind referrals could be explained more clearly. The meetings also need to be frequent enough so that information would not get lost in the process.

When different experts work together, there always is a potential risk for conflict and discordance. However, evidence-based programs may help reduce the risk. A continuing effort will help minimize the risk and maximize efficacy, so that an individualized care can be provided for each patient within the limited amount of resource. I turn next to another important consideration for providing individualized care, specifically age.

CHAPTER 2: MULTIDISCIPLINARY TEAM FOR DIFFERENT AGE GROUPS

Multidisciplinary care teams should vary in structure depending on the context. One example is the age group, as each age group demonstrates the unique social, medical, and psychiatric needs. In psychiatry, the age spectrum is divided into three main categories: children and adolescents, adults, and elderlies.

The general psychiatry concerns the adult population; most diagnostic and therapeutic approaches are centered on the adults. However, there is an increasing awareness that the child and the elderly group need different interventions because of their distinctive characteristics. In the following sections, I will describe how child and elderly population may exhibit different need, and how multidisciplinary team may need to be organized differently to flexibly address unique needs of each population.

Multidisciplinary Team for Children: Adverse Childhood Experiences Study (ACE study)

Child and adolescent population is unique because they are undergoing a developmental phase. Childhood is a critical period during which the biological, cognitive, and social development of an individual takes place, and exposure to traumatic events during this period may result in multiple health complications later in life.

The recent Adverse clearly demonstrates how childhood trauma can lead to serious health consequences, thereby emphasizing the need for a timely intervention in

addressing childhood mental disorders. The ACE Study is a large-scale study that assessed association between adverse traumatic events during childhood and long-term health consequences throughout the individuals' lifespan. The study involved more than 17,000 subjects, first recruited from 1995 to 1997 and followed thereafter for the long-term outcomes. The ACE questionnaire was used to assess the degree and extent of childhood trauma experiences, which included abuse (physical, sexual or emotional), neglect (physical or emotional), domestic violence, household substance abuse, household mental illness, parental separation or divorce, or incarceration of a household member (Anda and Felitti, 2003).

The study revealed that the prevalence of ACEs was high in our society; about two-thirds of the sample reported to have experienced ACEs at least once in their childhood, with 28% reporting to have experienced physical abuse, and 21% for sexual abuse (Anda and Felitti, 2003). The co-occurrences of ACEs were also common: 40% of the sample reported to have experienced two or more ACEs, and 12.5% of the sample experienced four or more ACEs (Anda and Felitti, 2003). ACEs were also common in the child and adolescent populations; the 2011–2012 National Survey of Children's Health (NSCH) reported that approximately 70% of children between the age 0 and 17 have experienced one or more ACEs (Bethell et al., 2014).

Outcomes of ACEs are not limited to biological health, but span over social, behavior, and psychological territories. ACEs are linked to higher rates of later-life occurrence of diabetes, chronic obstructive pulmonary disease (COPD), autoimmune diseases, cardiovascular complications, liver disease and obesity (Anda et al., 2008;

Corso et al., 2008; Dong et al., 2004; Dube et al., 2009). Psychiatric complications such as higher rates of substance abuse, suicide attempts, higher lifetime depressive episodes, impaired work performance, and high-risk sexual behaviors have also been reported (Anda et al., 2004; Anda et al., 2007; Dube et al., 2001; Dube et al., 2006; Hillis et al., 2001). Furthermore, ACEs put school-aged children at higher risks of behavioral challenges. Children who were exposed to socioeconomic hardship, divorce, familial mental illness, neighborhood violence, and incarceration of parents are more likely to be diagnosed ADHD, and greater ACE score correlated to greater disease severity (Brown et al., 2017).

The ACE study demonstrates how mental health risk factors during childhood lead to serious mental and physical health issues later in life. These results once again highlight the importance of early intervention. If the mental health risk factors can be managed in a timely manner, occurrences of corresponding health consequences in the future would also be reduced.

The study offers a valuable insight into how multidisciplinary care for mental health could be organized, as it provides a comprehensive description of the multi-faceted, multi-layered nature of the long-term impacts of ACEs.

First, biological factors need to be addressed by physicians. Childhood stressors may interfere with brain development and disrupt endocrine and the immune system, making children more vulnerable for physical and psychiatric illnesses later-on in their lives (Danese and McEwen, 2012; Moffitt, 2013; Rogosch et al., 2011). Physical illnesses

such as cardiovascular risk, diabetes, and obesity are usually addressed by primary care physicians. Therefore, doctors who are knowledgeable of the social determinants of health may help identify mental health factors by taking a detailed, pertinent history of a patient. When needed, psychiatrists may be consulted for a pharmacotherapy to the supplement disrupted neuroendocrine signaling system.

Second, the behavioral and cognitive function of a patient should be addressed. Children who experience ACEs are more likely to experience academic failure, behavioral problems and attendance problems (Stevens, 2012). Furthermore, children who experience ACEs have higher incidence of behavioral and cognitive complications such as Autism and ADHD, which may require a specialized education team and medical intervention (Brown et al., 2017; Kerns et al., 2017). It is important to educate the educators so that they can be aware of a variety of factors that may cause behavioral and cognitive problems; a knowledgeable educator would be an indispensable agent who can identify mental health risk factors early on in children's lives. Child psychiatrists and behavioral pediatricians, when needed, may further supplement the behavioral and cognitive growth of a child.

The psychodynamic and humanistic approach involves the understanding of an individual. Clinical psychologists and counselors assess a patient's psychodynamic changes and the possible causes including childhood trauma, and guide the patients to gain an understanding of their traumatic experiences. Through cognitive and behavioral therapy, clinical psychologists and counselors further encourage recovery and

empowerment. The importance of support and an advocacy group is also further emphasized at this stage.

Addressing ACE is an effort that requires multidisciplinary considerations and approaches. Any single framework would fall short in providing a full explanation. Treatment approaches should flexibly adapt different perspectives to best accommodate a patient's need. To provide a holistic, comprehensive care, flexible collaboration among different mental healthcare professionals would be crucial.

Multidisciplinary Team for the Elderly Population

Geriatric psychiatry concerns people of retirement age, most commonly defined at age 65 and beyond. The advancement in medical sciences led to the increase in life expectancy and the subsequent demographic aging of the population in the developed countries including the United States. As a result, health problems of the elderly, especially psychology of illness and aging, have become an important concern.

An elderly psychiatric patient is unique from other age groups in several ways. Their mental health problems are often inseparable from physical and social needs. The elderlies are often physically vulnerable and socially isolated, with an increasing number of the elderlies living alone. Addressing medical needs and accommodating social reintegration can lead to a significantly improved mental health outcome. Also, some mental illnesses, most notably dementia, is more common in the elderly population than any other age groups. Such mental illnesses can affect the prognosis of medical illnesses and the extent of social function of the elderly patients.

Furthermore, psychiatric and psychological care of older people require age-sensitive interventions. Older people may have impaired ability to understand medical concepts and to make decision for oneself. Their condition may sometimes be terminal, which may require the caregivers to change their focus from curing the disease to improving patients' quality of life by supportive measures. Many mental and physical illnesses can be chronic in the elderly population, which makes it important that healthcare providers remain resilient against workplace pessimism.

A multidisciplinary team in geriatric psychiatry should provide an age-sensitive care. Physicians, nurses, psychologists, occupational therapists, physical therapists, and social workers in a geriatric mental healthcare team need to understand unique needs of this population group so that the holistic, supportive care can be provided.

First, a psychiatrist should be aware of the unique characteristics of the elderly population. Common psychiatric problems in the elderlies include mood and anxiety disorders, dementia, psychosis and substance abuse. Some mental illnesses in old age may be treated successfully, but oftentimes they are chronic and progressive. Sometimes a psychiatrist may need to focus on improving patients' quality of life rather than attempting to cure the illness.

Assessment and interviewing of older people may need to be careful. It is recommended that elderlies receive initial assessment in their home or in a familiar setting, and invasive or stressful tests should be avoided unless necessary. Also, obtaining

a collateral history from family members and friends can be particularly important in this age group.

Multiple professionals will be involved and a psychiatrist should be ready to adequately orchestrate the multidisciplinary care team. A psychiatrist should be ready to make a care plan with follow-up arrangements. A psychiatrist may need to clearly define the responsibilities for members of the team, including primary care physicians, psychologists, nurses, social workers, occupational therapists, and physical therapists. Timely and thorough communication with rehabilitation home, day care center, residential facilities may be necessary to ensure continuity of care.

Medical doctors may play an important role in geriatric care team. Comorbidity is high in the elderly population. Patients commonly carry more than one psychiatric and medical diagnosis. Oftentimes, psychiatric patients will also have one or more medical illnesses. Psychiatrists and medical doctors often work in collaboration when it comes to the elderly patients. Sometimes, treating physical causes may relieve psychiatric symptoms. Treating dementia may slow the disease progression and prognosis. On the other side, pre-existing psychiatric illness may affect progression and prognosis of medical illness as well. Psychiatric illness may impair patients' memory, cognition, and behavior, which may subsequently affect patient's ability to be compliant with treatment plans including drug regimen and diet restrictions.

Furthermore, avoiding polypharmacy becomes important for old age patients. The elderlies are especially sensitive to side effects of psychotropic drugs. Psychotropic drugs

nay affect older patients' chronic medical illnesses. Medical doctors should ensure treatment of the coexisting physical problems, and acknowledge and monitor the side effects of the drugs.

Medical doctors are often the first one who sees the patients with mental illnesses. They should be able to identify when further specialist psychiatry care is needed and refer their patients to the service.

Psychotherapy for the elderlies needs to be specialized considering each patient's unique context. Past experiences significantly affect how a person perceives his or her own illness, and older people are more likely to have been exposed to multiple adverse and traumatic events, such as loss of the loved ones, physical and emotional abuse, or neglect. Such experiences may influence resilience and optimism in older people, which can significantly affect prognosis of both physical and mental health problems.

Lastly, occupational and physical therapists and social workers also play a crucial role in assisting old age patients. In the elderlies, physical therapy is often necessary to help them recover physical function so that they can regain autonomy to perform activities of daily living independently. Furthermore, such rehabilitative measures improve their safety at home. For the elderlies who are unable to care for themselves, referral to the residential house may be necessary.

The delivery of geriatric mental health care requires cooperation of multidisciplinary team including but not limited to medical physicians and psychiatrists, nurses, psychotherapists, occupational and physical therapists, and social workers. Training for all healthcare professionals should include adequate mental health component, and be age-sensitive and culturally appropriate.

CONCLUSION

In a psychiatric multidisciplinary team, different areas of expertise are combined to provide individualized care, so that the genetic, biological, social and behavioral needs of a patient can be holistically managed.

At present, multidisciplinary care is increasingly appreciated in other medical fields as well. The awareness that an illness happens in the social and environmental context is rising. Researches have proven that the onset and development of chronic diseases, including cardiovascular disease, type 2 diabetes, stroke, cancers, pulmonary diseases, and kidney diseases, are more frequent in those with lower socioeconomic status (Link et al., 2017), and this observed difference is due not only to differences in access to and quality of resources, but also to other social factors such as self-esteem, perceived inequality, self-motivation, sense of empowerment and self-direction, and social support, the variables that all relate to a person's place within the social spectrum (Marmot and Smith, 1991).

Owing to such findings, more and more programs are seeking ways to address socio-behavioral causes of a patient's disorder to encourage patient adherence, prevent relapse, and maximize the effect of the care. Thus, identifying elements of advantage and risks of the multidisciplinary team may have a far-reaching value. When creating the team, the first step should involve establishing the measures to delineate the roles and provide a window for communication.

In addition to being a solution to medical and cost concerns, the multidisciplinary care model is also ethically essential. Patients with certain mental illnesses are considered to have a little or no capacity to make a medical decision. Multidisciplinary care model is the most efficient way to help patients recover from their illnesses because it comprehensively addresses biological, psychological and social factors of illnesses. The model thereby facilitates patient's recovery of their agency, the ability to discern right from wrong, and autonomy, the right to make the decision that is most consistent with their beliefs and value systems.

An illness happens in multiple layers of physical and psychological contexts, thus recognizing and appreciating such multidisciplinary nature would be necessary for healthcare practitioners to effectively manage an illness. Through such effort, practitioners may achieve higher level of individualization of care, which can be a key in providing quality care to a wider range of people within the limited amount of time and resources. Furthermore, the multidisciplinary care model will enable patients to recover their moral agency and medical autonomy, and will empower them to make a fully informed decision. The multidisciplinary care model would be an imperative both medically and ethically.

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