Challenges and benefits in the creation of an interdisciplinary clinic

Jerry Gale

Dick Auerswald (1968, 1972, 1987) was one of the first family therapists to call for a broad-based ecosystemic perspective. A psychiatrist and early proponent of family therapy, he hired Jay Haley, Sal Minuchin and Braulio Montalvo to work at Wiltwick's Boy School. He argued mental health clinics *"must be developed that consist of a community-based health or mental health delivery system designed to operate ecosystemically and be staffed by people who can think ecosystemically"* (1987, p. 325). This was more than simply having practitioners of different disciplines working side-by-side, but required a systemic integration of all practitioners working in concert. Auerswald realised family issues extended outside the family interpersonal context and involved many other contextual factors. However, Auerswald also noted the challenges involved in establishing such clinics.

At the University of Georgia, we are in the early stages of developing our ecosystemic clinic. The ASPIRE clinic was established in 2010 (aspireclinic.org). Our services for both the university community and regional area include individual, couple and family therapy, financial education and counselling, nutritional education, home environment and design consulting, and legal problem-solving services. These services are offered both independently of each other and as combined services, such that an individual, couple or family could work with any combination of service providers either in a team approach or in tandem. The ASPIRE executive committee includes faculty from each discipline.

Prior to the creation of the ASPIRE clinic, we have provided couple and family therapy in the McPhaul Family Therapy Clinic which was established in 1985 and accredited by COAMFTE (Commission on Accreditation for Marriage and Family Therapy Education) in 1986. Housed in the College of Family and Consumer Sciences (FACS, formally Home Economics) the four departments in the college include Child and Family Development (CFD), Housing & Consumer Economics (HACE), Foods & Nutrition (FDN), and Textiles, Merchandising & Interiors (TMI). In the US, many COAMFTE-accredited programs began in colleges like home economics. When the history of home economics is reviewed, this is not surprising as it was home economics in the early 1900s that took the lead on child labour laws, healthy eating at home and in schools, and equal rights for women and other disenfranchised groups. While various administrators over the years advocated for a clinic combining the services of the different departments, due to numerous reasons (time, lack of resources for cross-disciplinary work, lack of interest from faculty, and a preferred institutional focus of basic science) only the family therapy program had an on-site clinic. However, in 2007, following a university funding-initiative to address poverty in the State of Georgia, faculty in FACS received funding for two collaborative proposals that brought together our different disciplines.

Jerry Gale (CFD & MFT faculty), Joseph Goetz (HACE), and two other faculty received funding for their proposal, *"Creating a conjoint financial counseling and couple counseling treatment model for couples on the threshold of poverty"* (Gale *et al.*, 2009; Kim *et al.*, 2011). Simultaneously, Lee Johnson (CFD & MFT faculty) and seven other faculty from the college received funding for their proposal, *The Effectiveness of Life Skills Literacy: A Pilot Study*. Gale and Goetz developed a five-session protocol in which marital and family therapy students paired up with financial counselling students seeing couples having both financial and relationship concerns. Johnson and his colleagues developed a protocol in which students training as therapists, financial planners, nutritionists and textile scientists (measuring the mold in the carpet) went into the homes of families referred by the Department of Family and Child Services for concerns about children's welfare. Each grant lasted about one and one-half years, and each model found both clinical successes and operational challenges.

The McPhaul Family Therapy Clinic continued to work with financial planning students and MFT students, following the grant. In 2009, Lee Johnson, as director of the MFT doctoral program instigated conversations with department heads and other faculty in FACS about creating a multidisciplinary clinic. Johnson's timing was based on a number of factors, including the success of the two poverty grants, and recent hires of faculty in the other college departments interested in the service side of their appointment. A core group of faculty came together to design and implement an interdisciplinary clinic.

In the creation of the ASPIRE Clinic, there was excitement as we all discussed the intersectionality of our work and the benefits of combining services. We all shared the view of how individuals', couples' and families' well-being included individual and relational dynamics, financial security (e.g. job loss, home foreclosure, bankruptcy, etc.), nutritional health, and home design and management (e.g. working to make the home a safe and relaxing place, addressing family change, such as elderly parents moving in, the birth of a child, returning adult children, as well as health disabilities and home organisation). Additionally, a law professor who oversaw free civic legal clinics run by our University's law

school joined our executive committee, bringing in law students to provide free legal guidance. As our training practice expanded to include students from all four disciplines, the students clearly saw the intersectionality of our work. For example, in one of our early practicums, the family therapist working with a mother and adult daughter (living together), and nutritional students on the other side of the mirror, heard the mother's account of childhood sexual abuse, and her father's affair with a pastry chef, and how this impacted her eating behaviours (anorexia) and relationship to eating in general.

One of the early outcomes we learned in the relational financial therapy grant was that a number of couples noted, when they agreed to participate, all they wanted was the financial counselling to address their financial issues, and would not have attended for just couple's therapy. However, they then found benefits in the combined work of financial and relational counselling. In particular, males noted their surprise at the benefits of couples' therapy. Our students across the disciplines also noted benefits in that they learned new skills and insights (both personal and professional) through the conjoint collaboration. Family therapy students learned skills for their own finances as well as questions and strategies to employ with clients, and financial counselling students noted learning communication and relationship skills to use with their clients, as well as personal insights about their own relationships. However, developing policies and procedures was (and is) a daunting task with numerous complications. At the end of 2010, we were able to get funding from our dean to hire a clinic coordinator. This was a key hire as the investment of time devoted to the clinic (which generally was not part of most of the faculty's employment and time allocation) was becoming very high. As each profession and discipline had its own unique policies, procedures, values and language, differences included: 1) codes of ethics and values, including different types of client/provider relationships, boundaries and privilege; 2) different fee structures; 3) different consent forms and research information (we want common data across all services) required very different information; 4) training the different service providers and their turn-over rate (students from some disciplines are in the clinic one or two semesters, while the family therapy students are there over two years); 5) the availability of rooms and coordinating scheduling; 6) developing memorandums of agreements with different agencies and groups in the community; 7) credit (or lack of credit) for faculty providing supervision (as the other departments never had their own clinic, they had no courses or arrangement with faculty to provide supervision); 8) integrating a scientist practitioner model that holds value to both the practitioner and the scientist; 9) developing new courses that involve students from all of the disciplines participating in a common class; and 10) articulating a shared theoretical model.

I believe what will be critical for our success includes articulating a shared theoretical model of our work as well as funding to show the benefits of our integrative model. To survive in a university setting will require we demonstrate outcomes that support faculty time and student learning. It is interesting to note that several of the members of the executive committee who are not therapists have clearly defined perspectives that are both systemic and embrace social justice. And it is from this point that I evoke Dick Auerswald's vision, espoused many years ago. The work we are doing at the ASPIRE clinic can provide rich resources to address clients' multiple contexts (home environment, diet, work and finances) that often family therapy does not include. It is hopeful that we will add to the discourse and literature the benefits of systemic practice across multiple disciplines.

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