Exploring the physician assistant-psychiatrist supervisory relationship and practice model at the Crisis Response Centre

Dana Skaritko PA-S, BSc

7785006

skaritkd@myumanitoba.ca

Mentors:

Dr. James Bolton, MD FRCPC

Dr. Geoffrey Konrad, MD FRCPC

A capstone project submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF PHYSICIAN ASSISTANT STUDIES

Department of Physician Assistant Studies

Max Rady College of Medicine and Faculty of Graduate Studies

University of Manitoba

Winnipeg, Canada

May 15, 2023

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ABSTRACT

Introduction: 1 in 3 Manitobans will be faced with a mental illness in their lifetime.[1] Given the limited number of psychiatrists in Manitoba, coupled with the high burden of mental illness in the population, physician assistants (PA) represent a critical resource in ensuring access to specialty psychiatric services. The Crisis Response Centre (CRC) is an innovative and resourceful 24/7 central access point for mental health services.[2] This study aims to determine how to best utilize PAs in practice at the CRC and ensure continued quality improvement in our healthcare system. **Methods**: This study examined the current supervisory practice model using an online survey distributed to both PAs and psychiatrists currently employed at the CRC. The survey focused on: 1. Gaining an understanding of the level of comfort in the current model from both psychiatrist and PA perspectives, 2. Identifying the roles and responsibilities that could be safely added if there was a change to practice, and 3. Examining PA- and psychiatrist-factors that influenced their level of comfort in the supervisory model. **Results**: Ninety-seven percent of psychiatrists agree that the presence of PAs has improved overall patient care at the CRC. There appears to be significant comfort under the current practice model from both PAs and psychiatrists and an evident willingness for PAs to have further autonomy, increased roles, and responsibilities. All PAs supported a model of only reviewing cases with which they are unsure of their management. **Conclusion**: Optimizing PA autonomy at CRC supports the community by utilizing the practice model to increase access to care and further this reach. It supports the growth of the PA model in psychiatry locally and nationally, as the CRC site is the principal employer of PAs in mental health in the country.

ACKNOWLEDGMENTS

I would like to thank my mentors, Dr. James Bolton, and Dr. Geoffrey Konrad, for their constant support, guidance, and expertise throughout this process. Thank you to all those at the crisis response centre for distributing and promoting this project so willingly. I am very appreciative of the ongoing feedback received from Ian Jones and Dr. Deni Pirnat over the course of the year. I would also like to thank my parents and partner, Chad, for their unwavering support and encouragement over the past two years. Finally, my brother Hunter, as the motivation behind this project and my guiding light. None of this would have been possible without each one of you.

INTRODUCTION

Mental illness is a widespread issue in Canada, affecting a significant portion of the population. 1 in 3 Canadians will experience mental illness at some point in their life.[1] In Manitoba, a study published in 2018 found that 27.6% of adults received a diagnosis of at least one of the examined mental illnesses.[3] The study also revealed that individuals with mental illness tend to utilize more healthcare services compared to those without, even when factors such as age, sex, income, and medical conditions are controlled for. Over a five-year period, Martens et al. found that 37% of the population in Manitoba aged ten and over had at least one healthcare contact coded with a mental illness diagnosis.[3] Individuals with personality disorders or those who have attempted suicide experience nearly three times the rate of emergency department visits compared to those without mental illness.[3] Considering the substantial prevalence of mental illness and the broad range of services utilized by affected individuals, it is imperative to implement an approach that guarantees access to specialized psychiatric services for all who require them.

The Crisis Response Centre (CRC) is an innovative and resourceful 24/7 central access point for mental health services beside Health Sciences Centre (HSC) in Winnipeg.[2] The purpose of the CRC is described as a "Centre of Excellence in crisis resolution [that] ensures expert short-term clinical treatment and support services are available through walk-in services, mobile services, and scheduled appointment services, combined with planned linkage and referral to appropriate services and supports."[2] Amongst the many allied health professionals that the CRC staffs as a part of their collaborative team, are physician assistants (PAs). Physician assistants have been employed in mental health positions in Manitoba since the initiation of the Master of

Physician Assistant studies (MPAS) program. Currently, six physician assistants are employed at the CRC, contributing to the recovery, and healing of mental health and wellness for Manitobans.

PAs in Canada are trained as medical generalists, and their scope of practice is determined by the specialty knowledge and experience they gain through a partnership with their supervising physician.[4] PAs play a significant role in providing patient-centered healthcare by utilizing a diverse array of medical services. These services include, but are not limited to, taking patient histories through interviews, performing physical examinations, executing certain diagnostic and therapeutic interventions or procedures, guiding patients on preventative healthcare, and undertaking any task within their proficiency delegated by the supervising physician.[5] The scope of practice for a PA is established on an individual basis and documented in a formal agreement or practice contract. This agreement is negotiated between the supervising physician(s), the PA, and frequently involves the facility or service where the PA will be employed.[5] The number of certified PAs in Canada continues to grow, there are now over 1000 PAs in the country.[6] The increasing utilization of PAs within our province has allowed physicians to manage a greater number of patients each day, leading to an improvement in overall patient outcomes.[6]

The PA role incorporates the concept of "negotiated performance autonomy", where the level of autonomy given to the PA increases as the supervising physician(s) gain confidence in the PAs knowledge and skills.[7] As a result, the PAs responsibilities and position evolve as they gain more experience, and this progression is contingent upon the development of the physician-

PA relationship.[8] Essentially, the PAs level of autonomy is a product of their professional growth and the trust they earn from their supervising physician(s). In a 2019 capstone project conducted by Sheena Graham[7], it was found that all PAs gain confidence in their role over time. Specifically, 86% of PAs reported feeling confident after one year on the job, with 96% feeling confident after 1.5 years, and 98% feeling confident after two years. However, it was noted that other factors, such as team size, number of physicians, and specialty, must also be considered when assessing the level of autonomy and independence a PA can achieve. The study further suggests that it generally takes around five years of experience for PAs to function with greater independence and minimal direct supervision.[7] In short, experience is not the sole determining factor in a PA's ability to work autonomously, and contextual factors must also be considered.

In a 2014 capstone project conducted by Ritika Upadhaya[9], PAs at the CRC reported diagnosing and providing treatment for a range of mental health disorders, such as psychotic disorders, mood disorders, anxiety disorders, and personality disorders. Additionally, PAs frequently encounter cases at the CRC involving suicidal assessments and abuse, including physical, emotional, and sexual abuse.[9] PAs at the CRC currently undertake the following responsibilities: 1) Conducting initial evaluations and psychiatric assessments of patients who are referred by front-line clinicians. This involves direct patient interviews, gathering and summarizing information from internal and external resources, reviewing previous pharmacological and non-pharmacological interventions, and conducting mental status exams. 2) Maintaining accurate documentation, establishing an appropriate working diagnosis, and creating disposition plans and/or follow-up plans. PAs are authorized to write medication prescriptions when necessary. 3) Referring patients to urgent psychiatric assessment clinics and follow-up in

the community. 4) Reviewing all cases with the on-call psychiatrist.[9] At the CRC, the existing practice model mandates that every case seen by a PA be reviewed by a psychiatrist prior to disposition, regardless of the PAs level of experience. However, in other settings, PAs may manage a full day or even a week of patients, with supervisory oversight limited to specific cases at the PAs discretion. In such scenarios, it is expected that physician support and guidance would be sought when needed.

Unfortunately, access to timely and adequate mental health care during crises remains a significant challenge in Manitoba. As the number of individuals experiencing mental illness and crises continues to rise, our healthcare system must be prepared to provide efficient and effective support to those in need. This requires a careful examination of how PAs can be best utilized in mental health practice at the CRC to achieve optimal patient outcomes. The objective of this project is to examine the comfort levels of both PAs and psychiatrists regarding increased PA autonomy at the CRC, and whether such comfort levels are influenced by experience level. Furthermore, the study seeks to assess the feasibility of modifying the current practice model. By studying the PA-psychiatrist supervisory relationship in this project, we can identify areas for improvement and expansion of current roles and responsibilities to increase PA autonomy and improve system efficiency. This approach will also help to measure satisfaction and utilization, ensuring continued quality improvement in mental healthcare delivery. This study therefore has the potential to inform practice changes to the PA model in mental health, and ideally make the system more efficient and responsive to the needs of all Manitobans who require mental health support.

METHODS

This quantitative study was conducted using surveys to assess opinions from both PAs and psychiatrists on their level of comfort in the current practice model at the CRC and about the prospect of greater PA autonomy. For each patient assessment conducted by a PA and reviewed with the psychiatrist, separate surveys were completed by the PA and psychiatrist related to that case just seen. Because completion of the survey was not mandatory, there were not always 2 survey responses generated for each patient seen. The clinical model at the CRC involves the PA seeing the patient directly and almost always on their own (without the psychiatrist), and then later reviewing the case in person. As such, the psychiatrist most often does not see the patient, although at times they will join the assessment if they feel it is indicated. An email link to the online survey (surkeymonkey.com) was distributed at the outset of the study to current PAs and psychiatrists employed at CRC, with an instruction for each to complete the survey for each case seen during the study period. The survey was to be completed after the case had been discussed and finalized with the psychiatrist and therefore, did not influence the clinical care provided in the case. They were to fill the survey out for new assessments only (since some patients may be reassessed multiple times during their visit to the CRC). Surveys covered similar topic areas but were specific to discipline (1 survey specific to PAs, and a separate survey specific to psychiatrists). The survey collected demographic and clinical information of the patient seen (age, sex, diagnosis, clinical comorbidities, disposition), comfort in managing the case, and the experience level of the provider. The independent variable investigated was level of experience. Specific survey questions can be found in Appendix 1. The data collection period was one month, open from December 15th, 2022 – January 15th, 2023. Two email reminders were distributed by Dr. Bolton, CRC director, as a reminder to complete the survey. Results were

analyzed by gathering summary data combining all levels of experience, and stratifying data based on years of experience working in psychiatry for both PAs and psychiatrists.

RESULTS

In total, there were 60 PA and 39 psychiatrist surveys completed. The majority (55%) of PAs working at the crisis response centre had 2 years or less of experience working in psychiatry. 45% had 5 years or greater (Figure 1). Comparatively, the level of experience of the psychiatrists employed at CRC were much more varied, with the majority (54%) having between 10-19 years of experience, but a notable proportion (26%) with less than 5 years of experience (Figure 2).

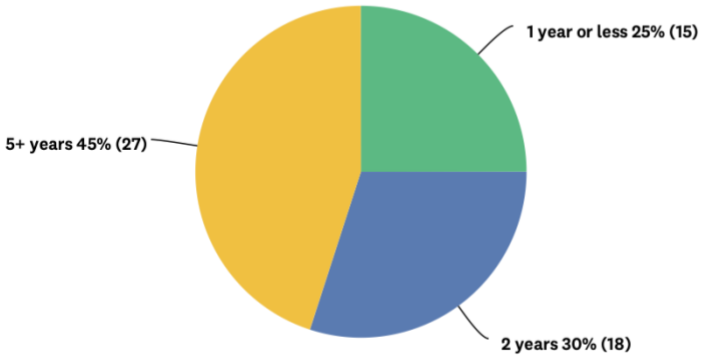


Fig 1. What is your level of experience as a physician assistant (PA) in psychiatry at the CRC?

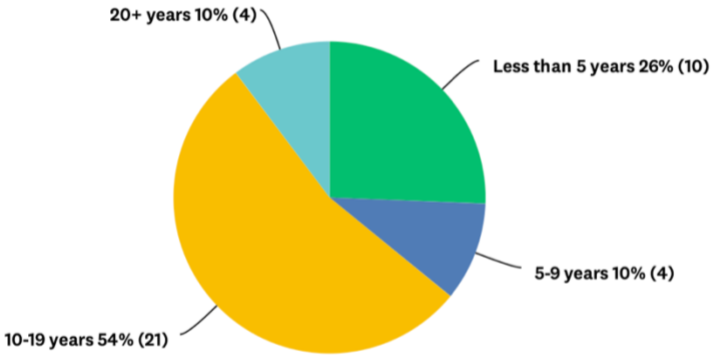


Fig 2. What is your level of experience as a psychiatrist at the CRC?

Clinical and demographic information of the patients assessed by the team are described in Table 1. Patients seen by PA and psychiatrists were most often between 18-35. Fifty-two percent of PA surveys involved male patients, whereas males were 64% of the surveys completed by psychiatrists. The most common primary diagnostic presentations were schizophrenia and suicidal ideation, for both groups. High rates of comorbid depression, alcohol and drug use disorders, and personality disorders were present among patients. Over 60% of cases were admitted to hospital (voluntary and involuntary), suggesting severe clinical presentations.

Table 1. Patient Demographics seen by PA and psychiatrists at the CRC

		PA surveys = 60; n (%)	Psychiatrist surveys = 39; n (%)
Age of patient	Under 18 Years	0 (0%)	0 (0%)
	18 – 24 Years	11 (18%)	9 (23%)
	25– 30 Years	14 (23%)	8 (20%)
	31 –35 Years	10 (16%)	5 (13%)
	36 – 40 Years	5 (8%)	4 (10%)
	41 – 50 Years	9 (15%)	5 (13%)
	51 – 60 Years	7 (12%)	3 (8%)
	60 Years and above	4 (7%)	5 (13%)
Sex of patient	Male	31 (52%)	25 (64%)
	Female	28 (47%)	14 (36%)
	Other	1 (1%)	0 (0%)
	Not disclosed	0 (0%)	0 (0%)
Primary diagnostic presentation of the patient	Suicidal ideation (without self-harm/attempt)	14 (23%)	15 (38%)
	Suicide attempt	2 (3%)	0 (0%)
	Non-suicidal self-harm	0 (0%)	0 (0%)
	Meth psychosis	6 (10%)	4 (10%)
	Schizophrenia or other psychosis	20 (33%)	12 (31%)
	Depression	8 (13%)	2 (5%)
	Mania	2 (3%)	1 (2%)
	Alcohol or drug use disorder	2 (3%)	1 (2%)
	Personality disorder	1 (1%)	2 (5%)
	Anxiety	1 (1%)	0 (0%)
	Situational crisis	2 (3%)	2 (5%)
	Other (specify)	2 (3%	0 (0%)

Comorbid diagnoses of the patient	Suicidal ideation (without self-harm/attempt)	30 (50%)	11 (31%)
	Suicide attempt	2 (3%)	1 (3%)
	Non-suicidal self-harm	2 (3%)	1 (3%)
	Meth psychosis	5 (8%)	4 (11%)
	Schizophrenia or other psychosis	11 (19%)	6 (17%)
	Depression	15 (25%)	13 (36%)
	Mania	3 (5%)	0 (0%)
	Alcohol or drug use disorder	14 (24%)	14 (39%)
	Personality disorder	15 (25%)	10 (28%)
	Anxiety	4 (7%)	2 (6%)
	Other (specify)	7 (12%)	7 (19%)
Final management / disposition plan	Voluntary admission to hospital	20 (34%)	10 (26%)
	Involuntary admission to hospital	17 (29%)	17 (44%)
	Referral to CSU	4 (7%)	1 (3%)
	Reassessment	3 (5%)	2 (5%)
	Discharge	14 (24%)	8 (20%)
	Transfer to ED	0 (0%)	0 (0%)
	Other (specify)	1 (1%)	1 (3%)

PA SURVEY RESULTS

From the perspective of the PAs, 97% of the management plans they had formulated independently were fully agreed upon and required no input or changes by the psychiatrists. 3% of the management plans required some input by the psychiatrist. In the cases requiring input, the PA had 2 years or less of experience (Figure 3a + 3b).

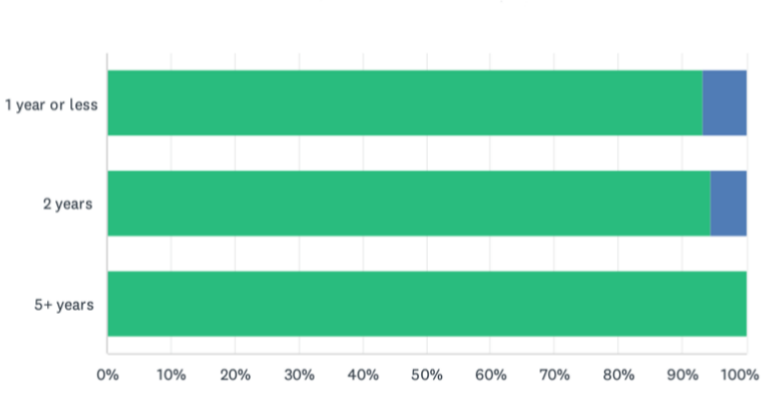


Fig 3a + 3b. PA response to the question: How was your management plan received by the psychiatrist?

In the 3% of cases that did require input from the psychiatrist, the PA noted that the psychiatrist suggested a different disposition or had different suggestions on the management of the patient during their visit to the CRC (Figure 4). In one case, input was required on the decision of whether to use a secure room due to suicide and AWOL risk.

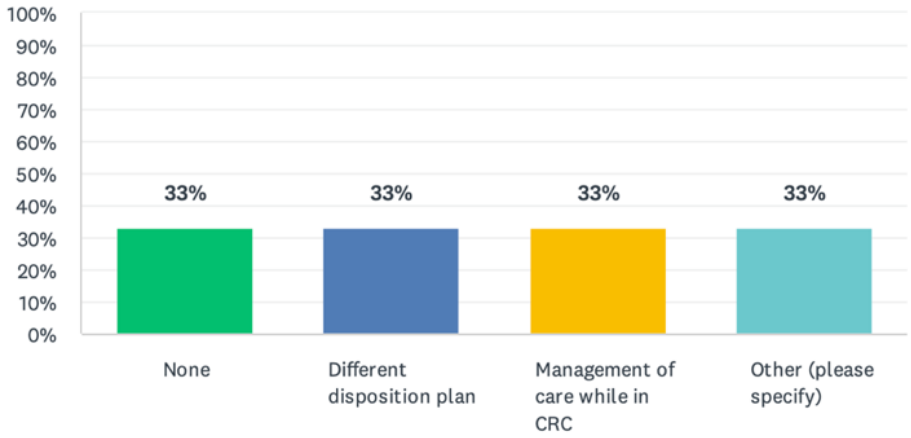
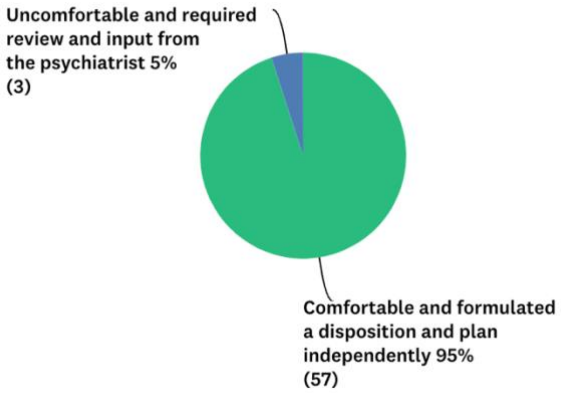


Fig 4. The management plan I formulated required input by the psychiatrist in the following areas (Check all that apply).

The majority (95%) of PAs felt comfortable with their management of the case they had just seen and felt able to independently formulate an appropriate clinical management plan (Figure 5a). In the 5% of PAs who felt uncomfortable with the case, the majority had 1 year or less of experience working in psychiatry (Figure 5b).



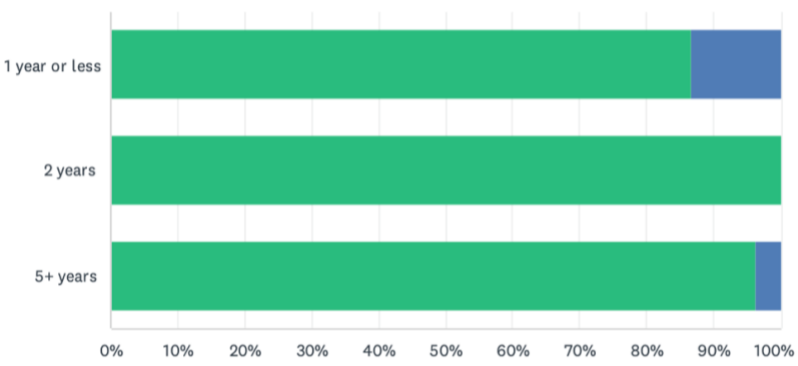
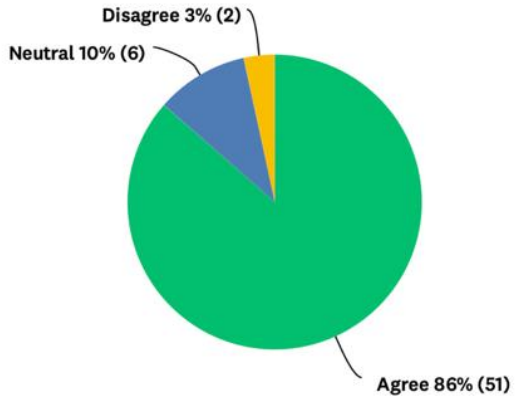


Fig 5a + 5b. PA response to: How did you feel managing this case?

When asked about their perspectives on possible changes to the PA-psychiatrist supervisory model at the CRC, 86% of the PAs stated they would feel comfortable if the CRC adopted a model where they could independently manage the case they had seen, and not require it to be reviewed with the psychiatrist (Figure 6a). There was a slight gradient with this degree of comfort based on level of experience, with 80% of 1st year of practice PAs expressing confidence with independence, whereas >90% of PAs with 5+ years of experience felt comfortable with managing their case independently (Figure 6b).



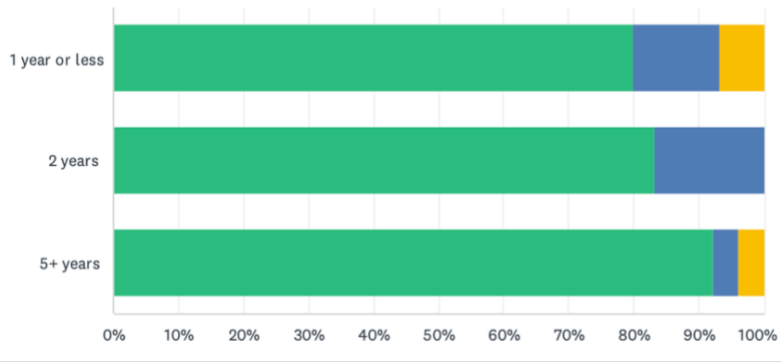
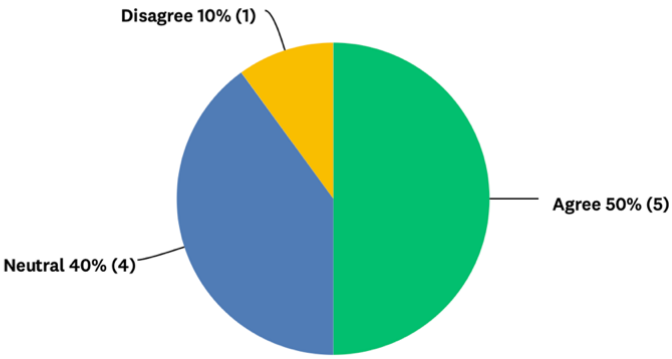


Fig 6a + 6b. PA response to: If CRC psychiatry adopted a model where not all cases seen by a PA required review, I would feel comfortable not reviewing this case with the psychiatrist and managing it independently.

All (100%) of the PAs that have 1 year or less of experience agreed that they would have felt more comfortable managing the case just seen independently if they received additional training.



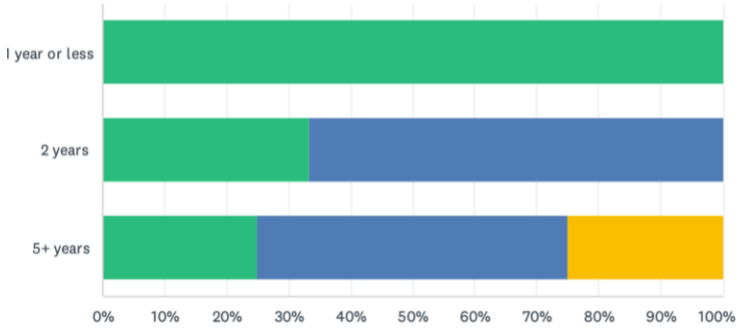


Fig 7a + 7b. PA response to: I would feel more comfortable managing this case independently if I received additional psychiatric training.

If there was an increased level of autonomy to their current role, all PAs supported a model of only reviewing cases with which they are unsure of their management (Figure 8). The majority (78%) of PAs would feel comfortable completing form 4s on their own. Thirty-two percent of PA responses liked a model of reviewing select cases at the end of their shift, rather than the current model of immediate review of each case.

*other: written response of completing form 4

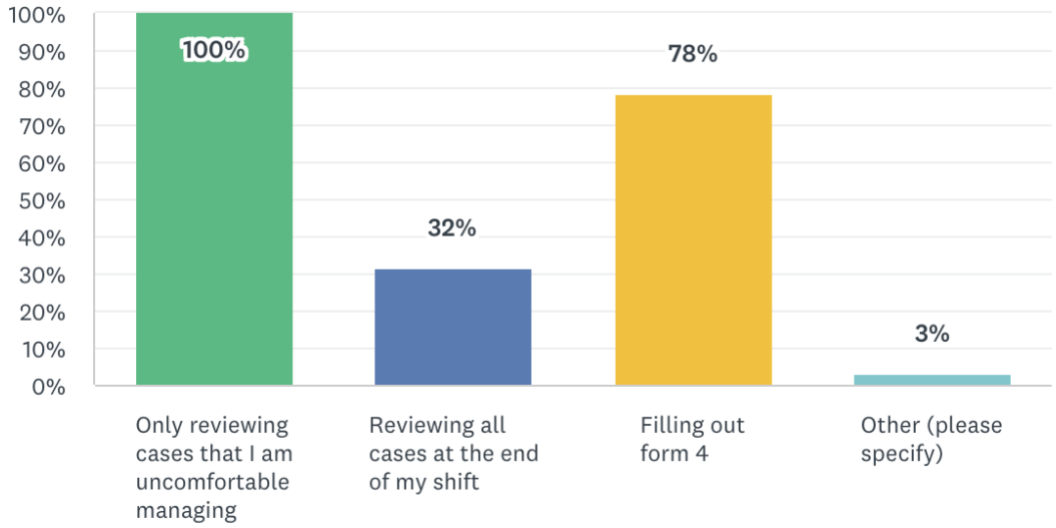


Fig 8. PA response to: What responsibilities would you feel comfortable to safely complete if there was an increased level of autonomy? (Check all that apply)

PSYCHIATRIST SURVEY RESULTS

From the psychiatrist perspective, almost all (95%) of the management plans formulated independently by the PA were completely agreed upon by the psychiatrist, requiring no change or input (Figure 9a). In the 5% of cases that the psychiatrist found the plan formulated to be

incomplete or required input, those responses overwhelmingly came from psychiatrists with greater than 20 years of experience (Figure 9b).

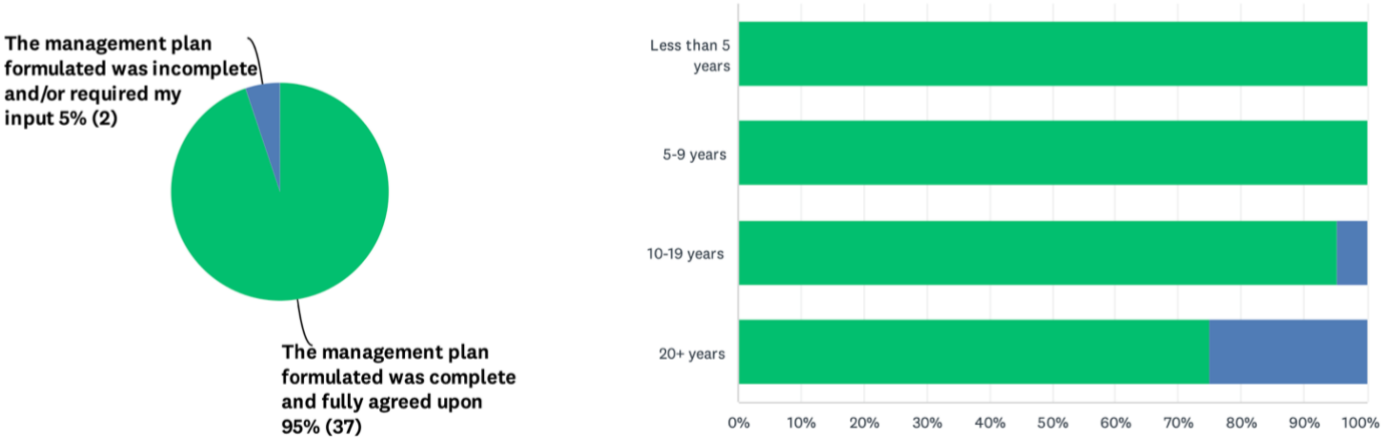


Fig 9a + 9b. Psychiatrists response to: How was the management plan presented by the PA?

In the 5% of cases that did require input or change, the psychiatrist felt that input was needed with medication management or follow-up treatment suggestions (Figure 10).

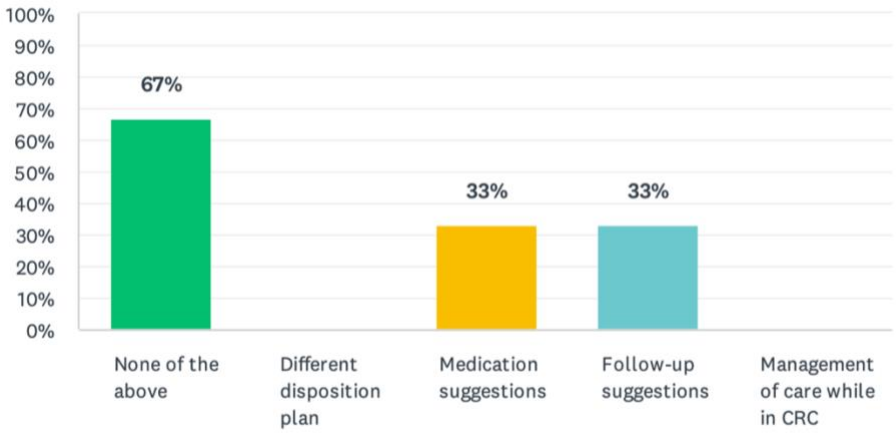


Fig 10. Psychiatrists' response to: The management plan formulated required my input in the following areas (Check all that apply)

Ninety-five percent of psychiatrists felt comfortable with the management of the case the PA had just seen, as well as the disposition plan they had formulated independently (Figure 11a + 11b).

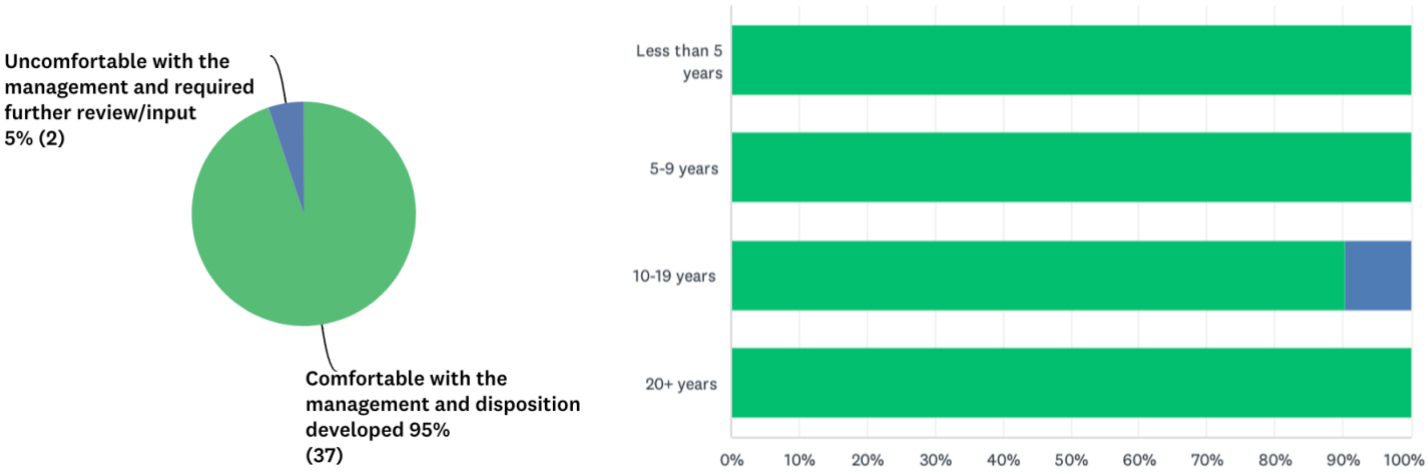


Fig 11a + 11b. Psychiatrists response to: How did you feel about the PA managing this case?

Eighty-two percent of psychiatrists felt that the case just seen by the PA did not require review, and they would have felt comfortable with the PA managing it independently (Figure 12a). Ten percent of psychiatrists stated the case did require review, and they would have been uncomfortable with the PA having increased autonomy to manage it independently. When stratified by psychiatrist experience level, those uncomfortable with the case being managed independently by the PA had greater than 10 years of clinical experience (Figure 12b).

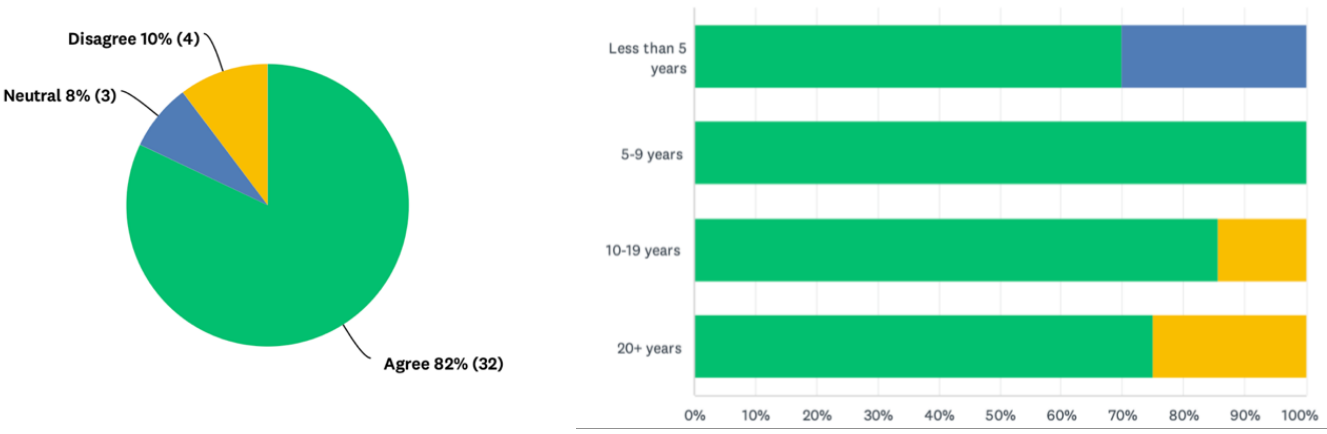


Fig 12a + 12b. If CRC psychiatry adopted a model where not all cases seen by a PA required review, I would feel comfortable not reviewing this case, and the PA managing it independently.

Most psychiatrists, 95%, expressed confidence in allowing physician assistants (PAs) to independently complete form 4s. They suggested two possible approaches for reviewing cases: either selectively reviewing cases that PAs are uncertain about (74% support) or conducting a full review of all cases at the end of each day (67% support). Psychiatrists also propose developing specific criteria to guide PAs in identifying cases that require further review, or recognizing cases that they are not equipped to handle independently (Figure 13).

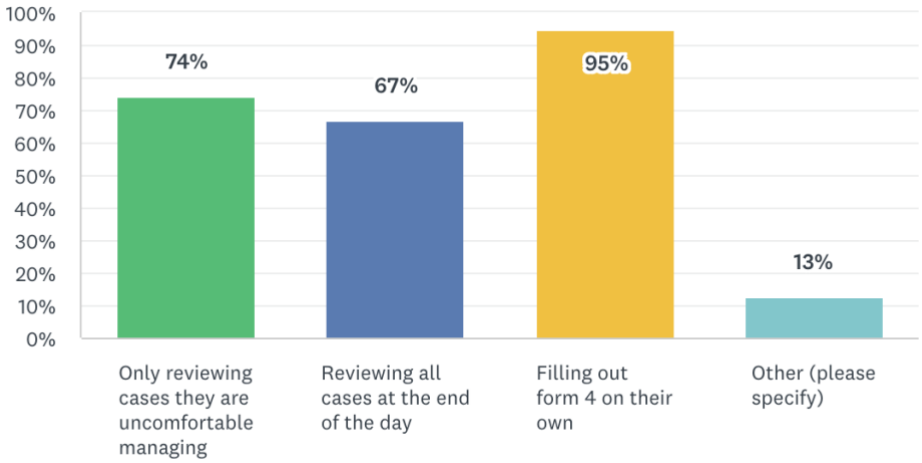


Fig 13. What responsibilities would you feel comfortable with the PA completing if there was an increased level of autonomy? (Check all that apply)

Nearly all psychiatrists agreed that the presence of a PA allowed them to focus more time on complex cases (Figure 14a + 14b).

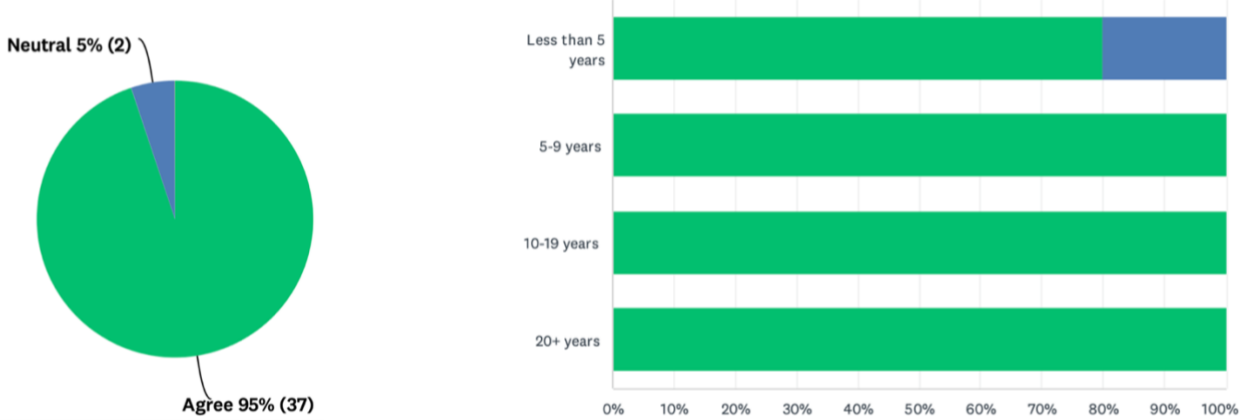


Fig 14a +14b. The presence of a PA safely allowed me to focus more time on complex cases

Ninety-seven percent of psychiatrists agree that overall patient care at the CRC has been improved by the presence of PAs (Figure 15a). One respondent (3%) was neutral to this statement (Figure 15b).

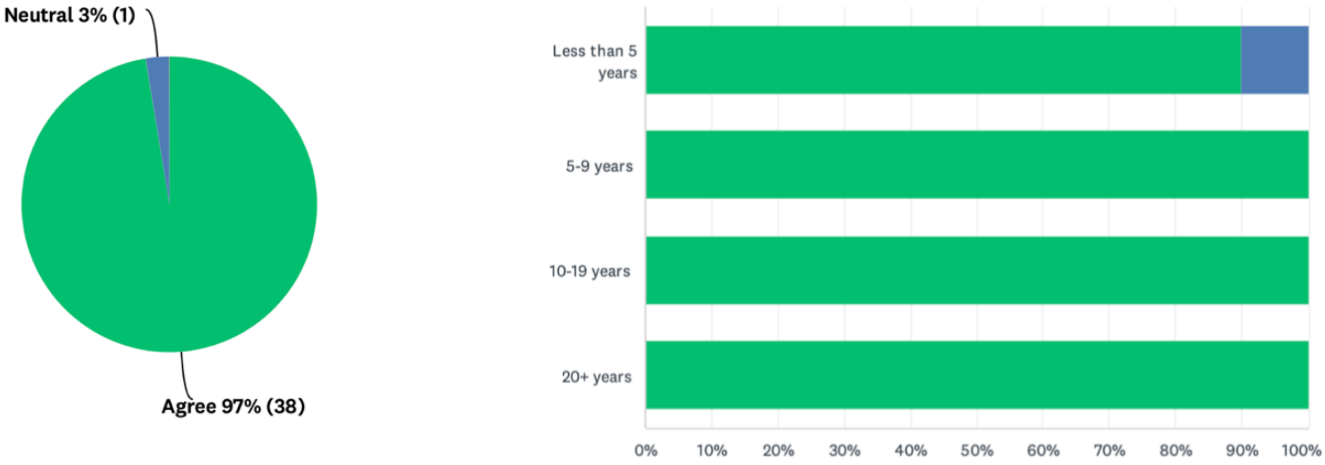


Fig 15a + 15b. Overall patient care at the CRC has been improved by the presence of PAs

DISCUSSION

This study was undertaken to examine PA and psychiatrist opinions about the supervisory model of care at the CRC, with the objective of optimizing PAs in practice and ensure continued quality improvement in our healthcare system. Results show significant comfort under the current practice model from both PAs and psychiatrists and an evident willingness of both providers for PAs to have further autonomy, along with increased roles and responsibilities.

The clinical cases which formed the foundation of the surveys demonstrated that PAs provide care to a highly acute patient population with severe presentations of mental illness. The PAs were commonly managing patients who were psychotic and suicidal, and more than 60%

were admitted to hospital, often involuntarily. Even in these emergent presentations, the vast majority of management plans created independently by PAs—which included medication suggestions, referrals, and disposition planning—were fully agreed upon by the supervising psychiatrist. Nearly all PAs (95%) reported feeling comfortable managing the cases they had just seen, with a small number of respondents (5%) indicating they were uncomfortable with how to manage the case. Of this 5%, all had one year or less of experience. This suggests that on-the-job training and gaining more experience throughout the years influences the comfort level of PAs when managing cases. As determined in a capstone project study by Sheena Graham[9], 86% of PAs felt comfortable in their role within one year. However, it was suggested to take approximately five years for PAs to function more independently and without direct supervision. This study will inform the development of a new practice model, taking into account that the CRC employs PAs with five years or more of experience. Furthermore, it was discovered that all PAs who had one year or less of experience stated that they would have felt more comfortable managing the case they had just seen if they had received further psychiatric training. In line with previous studies completed, our finding indicates that the length of time on the job is strongly correlated with increased training and proficiency.

According to questions in our survey pretraining to changes in responsibilities, all (100%) of PAs would prefer to review only those cases which they feel uncomfortable managing on their own, and almost 80% of them feel that they can safely complete form 4s if given increased autonomy (currently, from a legal standpoint, PAs are not allowed to act as a physician extender in completing Mental Health Act forms). The existing practice model includes the understanding that PAs will seek guidance and support when needed, which should continue in

the new model. The findings indicate that PAs are enthusiastic and willing to take on additional responsibilities, which would be advantageous for the healthcare system.

In general, the perspectives of the PAs were mirrored by the psychiatrists. According to psychiatrists, almost all cases and plans devised (95%) by the PAs were satisfactory without requiring any input. In the remaining 5% of cases, where psychiatrists deemed the plan incomplete, the majority of such cases were supervised by psychiatrists with over 20 years of experience. This implies that senior psychiatrists possess a more extensive and refined level of expertise, allowing them to offer additional suggestions and insights that may not be known or considered by those with less than ten years of experience. The cases that did require input required suggestions in the form of medication management and different follow-up plans. Ninety-five percent of psychiatrists felt utterly comfortable with the management of the case just seen by the PA and would have felt comfortable with the PA managing it independently, not reviewing it with them.

Regarding what roles PAs could take on in a new practice model, 96% of psychiatrists would like to have PAs fill out form 4s on their own. Eighty-seven percent agree with having PAs only review cases that they feel uncomfortable managing independently, with 13% stating there should be some criteria to help decipher when they should review the case with a psychiatrist. Currently, minimal research exists on how to determine which cases should require review, or what factors need to be considered. This is an area that further research can help to expand.

Notably, the impact of PAs at the CRC cannot be overstated. Ninety-six percent of psychiatrists agree that the presence of a PA safely allowed them to focus time on more complex cases. This finding is up from just 68% of psychiatrists agreeing to the same statement in a study completed by Ritika Upadhaya[9] in 2014. At that time, 14% of psychiatrists were neutral and 5% disagreed that the presence of a PA safely allowed them to focus time on more complex cases. Ninety-seven percent of psychiatrists agree that overall patient care at the CRC has been improved by the presence of PAs. This finding can be compared to just ten years prior when Upadhaya found only 68% of psychiatrists agree, and 32% were neutral to this same statement.[9] In our study, only one respondent expressed neutrality on this issue, and it was discovered that they had less than five years of experience. This raises the question of whether psychiatrists' familiarity with pre-PA patient care, dating back more than five years, affects their appreciation of the PAs and their contributions to patient outcomes at the CRC. Over the past ten years, the perception of the impact that PAs have has changed for the positive.

In Canada, access to mental health services has been a persistent issue. A substantial portion of individuals experiencing mental health crises resort to emergency rooms due to the absence of primary care and community-based mental health resources that can address mental health issues before they escalate[10]. This study confirms the role PAs can continue to play in improving the efficiency of the healthcare system. They can increase the number of patients seen in a day, relieving psychiatrists' workload, and potentially reducing wait times in ER.[11]

Our study has several limitations that should be acknowledged. Firstly, the number of PAs practicing in mental health in the province is limited, and our responses solely consisted of

the 6 PAs employed at the CRC. Although this is not representative of the entire population employed in other psychiatry positions, it is direct to studying the practice model at this facility. Secondly, our survey response rate varied between PAs and psychiatrists, with PAs filling out the survey 60 times compared to psychiatrists for only 39 cases. This may have influenced our results, as psychiatrists may have only completed the survey for cases they found to be managed better or had more time to complete.

Determining when a case should require review with a supervising psychiatrist is an important question that would benefit from further research.

In our busy world, we always seek to increase our efficiency without compromising safety and quality of care. We now have a deeper understanding of the comfort level of PAs in their current roles and responsibilities, as well as their desire for increased autonomy in certain areas. Additionally, the data indicates that psychiatrists are supportive of this change, which would ultimately lead to better patient care. This study is significant as it provides valuable insights into the direction of care by offering practical applications for change to the practice model at the CRC.

CONCLUSION

The feedback provided by psychiatrists regarding the performance of PAs in managing cases at the CRC is overwhelmingly positive. This presents an opportunity to expand their responsibilities in a new practice model, such as filling out form 4s and only reviewing cases that PAs are uncertain about. This increased autonomy can help to enhance access to mental health

care in the community, promoting the growth of the PA model in psychiatry both locally and nationally. This is particularly significant as the CRC site is the primary employer of PAs in mental health across the country, making it an ideal location to implement and refine new practices that will benefit patients and providers alike.

REFERENCES

1. Manitoba Health. COVID-19 Response: Manitoba's Roadmap to Recovery [Internet]. Winnipeg: Manitoba Health; 2021 [cited 2023 Mar 28]. Available from: https://www.gov.mb.ca/mh/docs/roadmap.pdf
2. Shared Health Manitoba. Crisis Response Centre [Internet]. Winnipeg: Shared Health Manitoba; [cited 2023 Mar 28]. Available from: https://sharedhealthmb.ca/services/mental-health/crisis-response-centre/
3. Chartier M, Bolton J, Mota N, MacWilliam L, Ekuma O, Nie Y, McDougall C, Srisakuldee W, McCulloch S. Mental Illness Among Adult Manitobans. Winnipeg, MB. Manitoba Centre for Health Policy. Autumn 2018. [cited 2023 Mar 28]. Available from: http://mchp-appserv.cpe.umanitoba.ca/reference/mh2015_Report_web.pdf
4. Jones IW, Hooker RS. Physician assistants in Canada. Can Fam Physician. 2011; 57(3)e83-3e88. [cited 2023 Mar 28]. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3056699/
5. Burrows K, Vanstone M, Jones I. PHYSICIAN ASSISTANTS. Introduction to the healthwork force in Canada.
6. Canadian Association of Physician Assistants [Internet]. Ottawa: Canadian Association of Physician Assistants; [cited 2023 Mar 28]. Available from: https://capa-acam.ca/
7. Graham S. Exploring Physician Assistant (PA) Autonomy and the Relationship between PAs and Supervising Physician(s) in Canada [masters capstone project on the internet]. Winnipeg, MB; University of Manitoba; 2017. [Cited 2023 Mar 28]. Available from: https://mspace.lib.umanitoba.ca/handle/1993/34819

8. Canadian Medical Association & Canadian Association of Physician Assistants. Physician Assistant Toolkit: A Resource Tool for Canadian Physicians. 2012.
9. Upadhaya R. WRHA Crisis Response Centre (CRC) Psychiatrist and Patient experiences with Physician Assistant-provided care using a standardized questionnaire survey [masters capstone project, unpublished]. Winnipeg, MB: University of Manitoba; 2014. [Cited 2023 Mar 28].
10. Slade M, Taber D, Clarke MM, Johnson C, Kapoor D, Leikin JB, et al. Best practices for the treatment of patients with mental and substance use illnesses in the emergency department. Dis Mon. 2007;53(11-12):536-580. [cited 2023 Mar 28]. Available from: https://pubmed.ncbi.nlm.nih.gov/18068802/
11. De la Roche M, Dyer N, Froats M, Bell A, McDonald L, Bolton C, et al. Effect of a physician assistant on quality and efficiency metrics in an emergency department. Can Fam Physician. 2021-2;67(2):e61-e67. [cited 2023 Mar 28]. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8324137/

APPENDIX

Survey to assess physician assistants' perception of practice in the supervisory relationship.

Case information	
What was the age of the patient in this case	• Under 18 Years • 18 – 24 Years • 25– 30 Years • 31 –35 Years • 36 – 40 Years • 41 – 50 Years • 51 – 60 Years • 60 Years and above
What was the sex of the patient in this case	• Male • Female • Other • Not disclosed
What was the primary diagnostic presentation of the patient (pick one – recognizing that SI/SA/NSSH occur within other diagnoses, they should be selected if that is the primary reason for psychiatric assessment)	• Suicidal ideation (without self-harm/attempt) • Suicide attempt • Non-suicidal self-harm • Meth psychosis • Schizophrenia or other psychosis • Depression • Mania • Alcohol or drug use disorder • Personality disorder • Anxiety • Situational crisis • Other (specify)
What were the comorbid diagnoses of the patient (check all that apply)	• Suicidal ideation (without self-harm/attempt) • Suicide attempt • Non-suicidal self-harm • Meth psychosis • Schizophrenia or other psychosis • Depression • Mania • Alcohol or drug use disorder • Personality disorder • Anxiety • Other (specify)
What was the final management / disposition plan for this patient	• Voluntary admission to hospital • Involuntary admission to hospital • Referral to CSU • Reassessment

	• Discharge • Transfer to ED • Other (please specify)
Practice information	

1. How was your management plan received	• The management plan I had formulated was fully agreed upon by the psychiatrist
	• The management plan I formulated required input by the psychiatrist in the following areas (check all that apply)
	  ○ Different disposition plan
	  ○ Medication suggestions
	  ○ Follow-up suggestions
	  ○ Management of care while in CRC

2. How did you feel managing this case	• I felt comfortable with the management of this case and was able to formulate a disposition and plan independently • I felt uncomfortable with the management of this case and did need to review to receive input with the psychiatrist
3. If CRC psychiatry adopted a model where not all PA cases required review, I would feel comfortable not reviewing this case with the psychiatrist and managing it independently	• Agree • Neutral • Disagree
4. I would feel more comfortable managing this case independently if I received additional psychiatric training	• Agree • Neutral • Disagree
5. What responsibilities would you feel comfortable to safely complete if there was an increased level of independence (check all that apply)	• Only reviewing cases that I am uncomfortable with the psychiatrist • Reviewing all cases at the end of my shift • Filling out form 4 • Other (Specifiy)
6. What is your level of experience as a physician assistant in psychiatry	• Less than 1 year • 2 years • 3 years • 4 years • 5+ years • 10+ years

Survey to assess psychiatrists' perception of PA practice in the supervisory relationship

Case information	
What was the age of the patient in this case	• Under 18 Years • 18 – 24 Years • 25– 30 Years • 31 –35 Years • 36 – 40 Years • 41 – 50 Years • 51 – 60 Years • 60 Years and above
What was the sex of the patient in this case	• Male • Female • Other • Not disclosed
What was the primary diagnostic presentation of the patient (pick one – recognizing that SI/SA/NSSH occur within other diagnoses, they should be selected if that is the primary reason for psychiatric assessment)	• Suicidal ideation (without self-harm/attempt) • Suicide attempt • Non-suicidal self-harm • Meth psychosis • Schizophrenia or other psychosis • Depression • Mania • Alcohol or drug use disorder • Personality disorder • Anxiety • Other (specify)
What were the comorbid diagnoses of the patient (check all that apply)	• Suicidal ideation (without self-harm/attempt) • Suicide attempt • Non-suicidal self-harm • Meth psychosis • Schizophrenia or other psychosis • Depression • Mania • Alcohol or drug use disorder • Personality disorder • Anxiety • Other (specify)
What was the final management / disposition plan for this patient	• Voluntary admission to hospital • Involuntary admission to hospital • Referral to CSU • Reassessment • Discharge

	• Transfer to ED • Other (please specify)
Practice information	

1. How was the management plan presented by the PA	• The management plan formulated was complete and fully agreed upon
	• The management plan formulated required my input in the following areas (check all that apply)
	  ○ Different disposition plan
	  ○ Medication suggestions
	  ○ Follow-up suggestions
	  ○ Management of care while in CRC

2. How did you feel about the PA managing this case	• I felt comfortable with the management of this case and the disposition and plan they developed independently • I felt uncomfortable with the management of this case and did need to further review the case to provide input with the PA
3. If CRC psychiatry adopted a model where not all PA cases required review, I would feel comfortable not reviewing this case and the PA managing it independently	• Agree • Neutral • Disagree
4. I would feel more comfortable allowing the PA to work independently on cases like this one if they received additional psychiatric training	• Agree • Neutral • Disagree
5. What responsibilities would you feel comfortable with the PA completing if there was an increased level of independence (check all that apply)	• Only reviewing cases that they are uncomfortable with the management of • Reviewing all cases at the end of the day • Filling out form 4 on their own • Other (Specify)
6. The presence of a PA safely allowed me to focus more time on complex cases	• Agree • Neutral • Disagree
7. Overall patient care at the CRC has been improved by the presence of PAs	• Agree • Neutral • Disagree
8. What is your level of experience as a psychiatrist	• Less than 5 years • 5-9 years • 10-19 years • More than 20 years