Collaborating in the Context of Co-location: An Interprofessional Collaborative Relationship Building Model

By

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Abstract

Background: Primary care providers, family physicians and nurse practitioners provide most mental health services in Canada. However, primary care providers lack knowledge, skills, and time to provide these services. Access to onsite mental health consultation or collaborative mental health care, affords primary care providers support to offer patients increased access to mental health services. Researchers suggest that interprofessional collaborative relationships are foundational to the success of collaborative mental health care. However, there is little understanding of how to build these relationships.

Purpose: The purpose of this grounded theory study was to develop an understanding of how primary care and mental health care providers collaborate to deliver mental health care in primary care settings.

Methods: Counsellors, family physicians, psychiatrists, nurse practitioners, and program leaders were recruited (N=40). Data were collected using individual (19) and focus group (7) semi-structured interviews. Interviews were audio recorded, transcribed and open coded. After open coding the first seven interviews, memos were written on each participant and focus group. These memos were sorted, compared to previous memos and then used to create a coding table. This iterative process of open coding, memo writing and then adding emergent codes to the coding table was repeated for all transcripts. Similar codes were grouped then collapsed to create the preliminary categories. Preliminary categories were sent to the participants after the primary care provider interviews and again after the provider focus groups to create the final categories. The final categories were compared to examine their relationships to one another.

Findings: The main finding of this study is a theoretical rendering of the participants' experiences and ascribed meaning of interprofessional collaboration to deliver mental health services in primary care. Specifically, a collaborative relationship building model with four developmental stages: 1) Primary Care Providers Need for Collaboration, 2) Initiating Co-location, 3) Fitting-in, and 4) Growing Reciprocity is offered.

Conclusions: The findings underscore that collaborative care requires an understood need for collaboration, organizational support, contextually effective modes of communication, and a perception that collaboration improves patient care. Further research may explore the applicability of this model to other health care contexts.

Dedication

I dedicate this work to my family:

To my mother and father who gave me solid values and a belief in myself that allowed me to pursue a level of studies that I would never have imagined attaining. To my mother who held her tongue wondering why this was taking so long and to my father who, although he is not physically with me today, I feel him along side of me every day.

To my boys, Corey and Daniel whose individuality inspires me to be my own person even if that meant finishing a degree at close to 60 years old. Thank you for your years of understanding and I look forward to demonstrating my cooking finesse for you and some stress free times ahead.

To my husband, my rock and my most definite cheerleader. Thank you for all you contributed to this very long journey. For many years you have been with me, listening to my ideas about codes and categories, methodologies, reading my work and giving me feedback. For as long as our children can remember you also took over all of the household chores and I thank you for stepping in. Most of all, I dedicate this work to you for loving me through it all.

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Structure and Organization of the Thesis

This thesis is comprised of an introduction, literature review, three interrelated manuscripts, knowledge translation, limitations and conclusion. One manuscript addresses the selection of research design and methodology and the other two manuscripts describe the key study findings.

Chapter 1 is an introduction to the study topic. Chapter 2 is an overall review of the literature and provides the study objectives and justification for the research. Chapter 3 introduces the first manuscript, Use of a Qualitative Methodological Scaffolding Process to Design robust Interprofessional Studies. Chapter 4 is the first manuscript that describes the scaffolding process used to select the study epistemology, theoretical underpinnings, methodology, and methods for this study. Chapter 5 describes the study design, methodology and methods. Chapter 6 provides an introduction to the findings. Chapter 7 is the second manuscript and addresses all four study objectives by describing the need primary care providers have for access to mental health experts, their experiences and perceptions of interprofessional collaboration, how the interprofessional providers developed their relationships to collaborate and provide mental health care in primary care settings, including the perspectives of the individual, groups of multiple providers, and regional leaders, and the challenges and opportunities for interprofessional collaboration to deliver mental health services in primary care settings. Chapter 8 is the third manuscript and addresses study objective 1 by describing the primary care providers' need for collaboration in detail. Chapter 9 is a concluding chapter that includes knowledge translation activities; recommendations for practice, policy, education, and research; study strengths and limitations; and conclusions. The reader will note

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redundancies between Chapters 1 (Introduction), 2 (Literature Review), 3 (Introduction to

Epistemology, Theoretical Perspectives and Study Design) and 5 (Study Design), with

Chapters 4, 7 and 8 as these chapters were published or submitted for publication as

stand-alone manuscripts that each required in-text citations and references. The

references for chapters 1-3, 5, and 9 are located at the end of this document.

CHAPTER 1: INTRODUCTION

Rates of mental illness amongst Canadians are high and have remained consistent since 1997 (Simpson, Meadows, Frances, Patten, 2012). According to the results of the 2012 Canadian Community Health Survey-Mental Health, 12.6% or 3.5 million Canadians will experience depression (11.3%) or bipolar disorder (2.6%) or/and 8.7% or 2.4 Canadians will experience an anxiety disorder during their lifetime (Pearson, Janz, & Ali, 2013). In 2012, 10% of Canadians experienced a mental disorder in the past year. The impact of these disorders on the individual, family, and community is acknowledged to be extremely high (Stein, Pearson, Goodman, et al., 2014; Whiteford et al., 2013) with some suggesting that mental illness ranks first in years lived with disability (YLDs) and disability-adjusted life years (DALYs) (Vigo, Thornicroft, & Atun, 2016). The Global Burden of Disease Study Collaborators (2015) reported that depression was one of the top ten causes of YLD of the 188 countries included in their analysis. Mental and substance abuse disorders are ranked as the leading global cause of non-fatal burden of disease (Whiteford, et al., 2013, p. 1579).

Furthermore, mental illness is intricately intertwined with chronic physical disease (Dickey, Normand, Weiss, Drake, & Azeni, 2002; Trivedi, 2004). People with chronic mental disorders are 75% more likely to have a co-morbid chronic physical disease, such cardiovascular disease (Rugulies, 2002), gastrointestinal disorders (Dickey et al., 2002), diabetes (Broemeling, Watson, & Black, 2005; Dickey et al., 2002; Egede, Zheng, & Simpson, 2002) and/or pulmonary disease (The Standing Senate Committee on Social Affairs, Science and Technology, 2006; Jones et al., 2004). Of those people who seek help for mental health concerns, half have a concurrent physical diagnosis (Lin,

Goering, Offord, & Boyle, 1996). As well, people with chronic physical diseases such as chronic back pain (Rush, Polatin, & Gatchel, 2000) or heart disease, (Durbin, Goering, Streiner, & Pink, 2004; Gilmour, 2008) are more likely to experience a co-morbid psychiatric disorder (Sartorious, 2013). Individuals with a mental disorder are at increased risk to have more than one chronic physical disease when compared to those without a mental disorder (Dickey et al., 2002). Finally, findings from a recent review of systematic reviews revealed that, mental illness might shorten an individual's lifespan by up to 20 years (Chesney, Goodwin, & Fazel, 2014). Early diagnosis and access to appropriate treatment lessens the burden of mental illness leading to better health outcomes (Davis, Martin, Kosky, & O'Hanlon, 2000; Durbin et al., 2004; Health Canada, 2002). However, there is a lack of timely access to treatment and a fragmented system of care (Patten, 2004; Patten & Beck, 2004) resulting in most Canadians living with mental illness not receiving appropriate treatment (Lesage, 2006; Ontario Hospital Association, 2014; Toronto Central Local Health Integration Network, 2013; Ross, et al., 2015; Sunderland & Findlay, 2014).

According to the Centre for Addiction and Mental Health (2016), establishing and maintaining visits with a primary care provider can positively impact the health of individuals with mental illness. Approximately 80% of individuals visit their family physician at least once per year and mental illness is one of the top reasons for the visit (Fransoo et al., 2013). Canadians experiencing mental health concerns first seek the attention of a primary care provider (PCP), either a family physician or nurse practitioner (Health Canada, 2005; Ross et al., 2015). Thirty to forty percent of patients seen in primary care have an identifiable mental health problem (Ansseau et al. 2004) with

approximately 10% of primary care patients meeting the criteria for a major depressive disorder (Craven & Bland, 2013). Approximately one third of Canadians with a mental health disorder receive care only from their family physician (FP) and another 25% of patients receive care from both their family physician and a mental health provider such as a psychiatrist or counsellor (Craven, Cohen, Campbell, Williams, & Kates, 1997; Lesage, Goering, & Lin, 1997). Jacob and Patel (2014) reported that 90% of mental health care is provided by professionals other than psychiatrists. Family physicians report that 25%-50% of their time is spent attempting to meet the needs of patients with mental health concerns. Family physicians see more mental health patients than the number of patients seen by mental health specialists (Macfarlane, 2005; Richards, Ryan, McCabe, Groom, & Hickie, 2004). Moreover, primary care physicians have an ongoing relationship with patients and knowledge of patient histories including their physical and social environment. Comprehensive knowledge of the patient allows the physician to integrate all aspect of health including physical and mental health, situating the physician to provide continuity of care (Kates et al., 2011).

Furthermore, the Mental Health Commission of Canada (2013) stated that the mental health system remains fragmented and that all those experiencing mental health problems "should be able to count on timely access" to services (p. 52). Moreover, these authors recommended that individuals receive the most appropriate care while accessing the least intensive treatment required. For many Canadians with common mental disorders such as depression and anxiety, receiving the most appropriate care and least intensive mental health care, means having access to primary mental health care (Bower,

2002; Bower, Knowles, Coventry, & Rowland, 2011; Kates & Mach, 2007; Katon et al., 1996; Rothman & Wagner, 2003).

However, family physicians and nurse practitioners report not having the training, skills, or time required to deal with the variety of mental health problems they see in their practice (Canadian Nurses Association, 2010; Macfarlane, 2005). Additionally, in the past, family physicians reported moderate levels of comfort with prescribing, detecting, assessing, counselling, and referring their patients with mental health problems (Swenson et al., 2009). Prescribing medication for depression was the one exception where the level of comfort is high for the majority of family physicians. Moreover, primary care physicians feel unprepared to provide service to patients experiencing multiple health issues simultaneously, especially when this includes mental health concerns (Schoen et al., 2006). A lack of time and expertise often leaves patients not receiving the mental health care they require.

To provide mental health services in settings where patients present, family physicians and nurse practitioners must be equipped to provide services in primary care settings. Therefore, these family physicians and nurse practitioners must develop partnerships with experts in mental health such as psychiatrists and mental health counsellors (Kates, et al., 2011). This need for partnership was formally recognized in 1997 and again in 2011 when the Canadian Psychiatric Association and College of Family Physicians of Canada called on their members for better collaboration amongst psychiatrists and FPs in the treatment of patients seeking mental health care in primary care settings (Kates, Craven, Bishop et al., 1997; Kates et al., 2011).

In the mid-1990s, there was also a more general recognition that patients presenting to primary care have complex medical issues and/or chronic illnesses and require the simultaneous services of different health care providers (Hutchison & Glazier, 2013). In the late 1990s, less the 10% of Canadian FPs worked in interprofessional teams, although there was a national call to require interprofessional practice (Hutchison, Abelson, Lavis, 2001). The dialogue and call for improved partnership continues and includes non-physicians such as patient educators, care managers, nurse practitioners, psychologists and mental health counsellors (Kates et al., 2011; O'Malley & Reschovsky, 2011). Although there is a long-standing recognized need for these health care professionals to work together, these partnerships are evolving and continue to require attention (Craven & Bland, 2006; Kates, et al., 2011; Wienerman, Campbell, Miller, Stretch, Kallstrom, Kadlec, & Hollander, 2011).

The status quo of health care providers working independently without relating to other providers is one of five major concerns in primary care (Government of Canada, 2003; Hutchison & Glazier, 2013; The Standing Senate Committee on Social Affairs, Science and Technology, 2006). Earlier evidence suggests that working in interprofessional teams can improve the efficiencies of the health care system, improve patient safety and deliver improved outcomes (Canadian Health Services Research Foundation, 2007; Clement, Dault, & Priest, 2007; Health Canada, 2002; Wagner, 2000). However, some have suggested that although interprofessional collaborative practice may result in positive effects, successful implementation has been difficult (Gaboury, Lapierre, Boon, & Moher, 2011; Legare, et al., 2013)

Interprofessional care, the provision of comprehensive health services to patients by multiple health care professionals working collaboratively, is the current best practice for all areas of health including delivery of mental health services in primary care (Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, 2007; Health Canada, 2008; Herbert, 2005). Policy makers recognize that delivering mental health services within primary care relies heavily on primary care generalists and mental health specialists collaborating to provide quality mental health service in primary care settings (Canadian Health Services Research Foundation, 2006; Romanow, 2002). This recognition of the need for collaboration resulted in the development of Shared or Collaborative Mental Health Care (CMHC) (Kates, Craven, Bishop et al., 1997; Rockman, Salach, Gotlib, Cord, & Turner, 2004). Across Canada, many jurisdictions have implemented a model of CMHC (Kates et al., 2011; Kates & Ackerman, 2005; Rockman et al., 2004). To date, there is little understanding of the process and structures that support the development or building of collaborative relationships within the CMHC team. A model or guide that illuminates the structures and process that build interprofessional collaborative relationships within the CMHC is an essential missing link to developing best practices that will ensure patients with mental health concerns receive the full benefits of the interprofessional team.

Purpose

The purpose of this qualitative study was to broaden and deepen our understanding of interprofessional collaboration in primary care. The specific focus of the study was on the relationship building process of the CMHC team in response to individuals' mental health concerns. Exploring the relationship building process from the

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emic perspective included understanding the perspectives from the micro (i.e., individual care provider), meso (i.e., multiple or groups of care providers), and macro (i.e., system or program leaders) perspectives, as well as the interface between these perspectives. The perspectives and experiences of individual health care professionals, groups of providers, and the CMHC program leadership group were included in this study. The research objectives for this study were:

1. To understand primary care providers' need for interprofessional collaboration to deliver mental health services in primary care settings.

2. To detail the primary care providers and mental health care providers experiences and perspectives of interprofessional collaboration of building in the context of a Collaborative Mental Health Care service.

3. To understand how the perspectives of individual provider (micro), the multiple providers (meso), and service leaders (macro) influence the interprofessional collaborative process in the context of a Collaborative Mental Health Care service.

4. To explore the opportunities and challenges of interprofessional collaborative relationship building in the context of a Collaborative Mental Health Care service.

Significance

If primary care is the future to a sustainable health care system then patients must be able to address their mental health needs in primary care settings. To provide primary care including mental health care to all Canadians, teams of health care providers must work together in this treatment setting. Interprofessional collaborative care is considered today's best health care practice.

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This resulting interprofessional collaborative relationship building model (Wener & Woodgate, 2016) that describes relationship between providers emerged. The relationship amongst providers is at the heart of interprofessional collaboration, yet to date the relationship building process has not been studied in detail in the CMHC treatment setting. Understanding the IPC relationship building process from the perspectives of those delivering the treatment as well as, those who lead the CMHC program is a much needed, first step that will inform team members attempting to navigate the complex interprofessional relationship. More broadly, the model may be tested for its application to other areas of primary mental health care and areas of chronic care disease management.

CHAPTER 2: LITERATURE REVIEW

This literature review provides an overview of what is known in three areas related to this study: i) interprofessional collaboration, ii) interprofessional collaboration in primary care, and iii) collaborative primary mental health care. This literature review also provides rationale for the need to study the collaborative relationship building process by addressing current gaps in knowledge.

World-wide, interprofessional collaboration where teams of professionals from different backgrounds work together, is thought to provide best practice (WHO, 2010) and most cost effective patient care (Borrill et al., 2001). In Canada, there has been a call for increased interprofessional collaboration (Romanow Report, 2002) that called for the patients', families' and communities' needs to be prioritized. Interprofessional collaboration could fulfill these needs by providing the health care professional who was the most competent to deliver the service in a timely fashion (Herbert, 2005). At the same time, there were also concerns that without appropriate planning, there would be a national shortage of health care personnel that would render Canadians lacking access to needed health care personnel (2003 Canadian First Ministers Health Accord on Health Care Renewal; Romanow, 2002; Senate Standing Committee on Social Affairs, Science & Technology, 2006; WHO, 2010). To this end, Health Canada along with the provinces and territories developed a national health human resources strategy that focused on health care provider planning and retention (Herbert, 2005).

The anticipated shortage of health care professionals was especially concerning given that the Canadian population are aging. As many authors have reported with an aging populations there is also an associated increase in these individuals presenting with

multiple and complex health care problems, including anxiety and depression (Broemeling, Watson & Prebanti, 2008; Katon, et al., 2010). In response to the anticipated growth in health care needs of Canadians and the impending shortage of health care professionals, there was recognition that health care professionals can only meet the needs of Canadians if they work together (Herbert, 2005; Trivedi et al., 2013).

Interprofessional Collaboration

Defining interprofessional collaboration: Collaboration in everyday life is most often thought of as a group of individuals collectively working on a joint project (Collaboration, n.d.). Wood and Gray (1991) analyzed the concept of collaboration and offered the following definition, "Collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structures, to act or decide on issues related to that domain" (p. 146).

After conducting an extensive review of the literature, D'Amour and Oandansan (2005) suggested the term interprofessional collaboration as a specific type of collaboration between health care providers from different professional backgrounds. The World Health Organization (WHO) identified the need for interprofessional collaboration due to an impending shortage of health care workers, a fragmented health care system that was not meeting the populations' needs, and a belief that interprofessional collaboration could mitigate these issues (WHO, 2010). Collaborative practice as defined by the WHO (2010) occurs when multiple health professionals work with patients, their families, and communities to deliver the highest quality care in all practice settings.

Although there is no single definition of interprofessional collaboration the many definitions do share some common features. A group of researchers from the United

Kingdom defined interprofessional collaboration as, "an active relationship between two or more health or social care professions who work together to solve problems or provide services" (Freeth, Hammick, Reeves, Koppel, & Barr, 2005, p.xiii). Definitions of interprofessional collaboration emphasize that it involves more than one health care provider, that the providers are from different professional backgrounds, and that these teams of providers are better able to deliver quality care. Therefore, for the purpose of this paper interprofessional collaboration is defined as the relationship and interactions developed amongst the health care providers from a variety of professional backgrounds who work together to provide high quality patient care.

Other researchers have described some of the qualities of interprofessional collaboration. For example, a group of Canadian researchers described interprofessional collaboration as a dynamic process that includes sharing, partnership, interdependency, power, and process (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005). The Canadian Health Services Research Foundation (CHSRF) described interprofessional collaboration as, a process that requires relationship and interaction between health professionals and varies depending on the complexity of health care needs and the numbers of professionals working to address those needs (CHSRF, 2007). These authors emphasized the importance of the relationships and interactions amongst the health care providers and how these are not static entities.

Others have suggested that interprofessional education, pre- and post-licensure, is an important tool that helps to develop the skills required for interprofessional collaboration (Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013; WHO, 2010). According to the Centre for the Advancement of Interprofessional Education (2016),

interprofessional education occurs when learners from two or more professions learn with, from, and about each other to improve care. The WHO stated that pre-licensure interprofessional education is required to prepare health care professionals to practice interprofessionally (WHO, 2010). Post-licensure interprofessional education and collaborative practice is thought to have resulted in many benefits such as increased access to services (Mickan, 2005), improved practices and productivity (CHSRF, 2007), improved patient outcomes and safety (Lemieux-Charles, 2006) and increased staff morale (Mickan, 2005). In a recent Cochrane review of pre- and post-licensure interprofessional education randomized control trials, controlled before and after studies, and interval time trials, Reeves et al. (2013) found that interprofessional education resulted in positive interprofessional collaboration in diverse areas of practice such as diabetes care, emergency care, and mental health. These authors also reported improvement in patient-centred communication and operating room communication after an interprofessional education intervention. While there does seem to be some suggestion that interprofessional education may be used to improve interprofessional collaboration, only a small number of studies have included sufficient rigour to be included in the Cochrane Review. Knowing that interprofessional collaboration has benefits, researchers have attempted to clarify the competencies required to work together with others from various health care backgrounds.

Interprofessional collaboration competencies: Internationally, researchers have attempted to describe the competencies required to collaborate with other health care providers to provide high quality care. Barr (1998) identified three types of competencies, those that are common, complementary, and collaborative. Common competencies are

the knowledge and skills held by all professions. The common competencies are those skills that all health professions require and are common to more than one professional on a team. An example of a common or overlapping competency is interviewing skills. Complementary competencies are the unique skills and knowledge held by one professional group that balances the skills and knowledge of providers' skills and knowledge from other professions. The collaborative competencies are the knowledge and skills that every professional requires in order to collaborate with others, interprofessionally, intra-professionally, with patients, and within organizations (Barr, 1998).

While individual professions have developed specific competency documents that require health professionals to be aware of the skills of others to work well together, Barr (1998) called for the development of interprofessional collaborative competencies between health care practitioners. Researchers have reported elements required for interprofessional collaboration. Suter et al. (2009) reported that two competencies were key: understanding and valuing one's own and others' professional roles and responsibilities, and effective communication. Other researchers have highlighted that collaborators require a commitment to patient-centred care where the individual or family are included in the treatment planning (Herbert, 2005; Orchard, Curran, & Kabene, 2005). Orchard et al. (2005) also highlighted power sharing and developing trusting relationships as enablers of interprofessional collaboration. Additionally, interprofessional collaboration requires clear goals, shared team identity and commitment, and integration of work practices (Reeves, Lewin, Espin, & Zwarenstein, 2011, Sargeant, Loney, & Murphy, 2008).

Thistlethwaite et al. (2014) identified interprofessional collaboration competency documents from four countries that are not profession specific: The Interprofessional Capability Framework from the United Kingdom (Combined Universities Interprofessional Learning Unit, 2006), the Core Competencies for Interprofessional Collaborative Practice in the USA (Interprofessional Education Collaborative Expert Panel, 2011), Curtin University's Interprofessional Capability Framework from Australia (Brewer & Jones, 2013) and the National Interprofessional Competency Framework from Canada (Bainbridge, Nasmith, Orchard, & Wood, 2010). Although the documents vary in some areas, there is a great deal of similarity in terms of the overall domains of interest. All of these competency documents include an overarching need to be competent in providing safe and quality care, understanding the interprofessional providers' roles, team development and dynamics, interprofessional communication, and patient-centred care (Canadian Interprofessional Health Collaborative, 2010; Brewer & Jones, 2013).

As the study described in this thesis took place in a Canadian context, the Canadian Interprofessional Health Collaborative (CIHC) National Interprofessional Collaboration Competency Framework will be explored in greater detail. In 2010, after an extensive review of the literature, the CIHC described that professionals must acquire competency in six domains to be prepared to practice interprofessionally. Two competencies, patient/client/family/community-centred care and interprofessional communication support the other competencies. The other competencies include role clarification, team functioning, collaborative leadership, and interprofessional conflict resolution (Figure 1, CIHC, 2010).
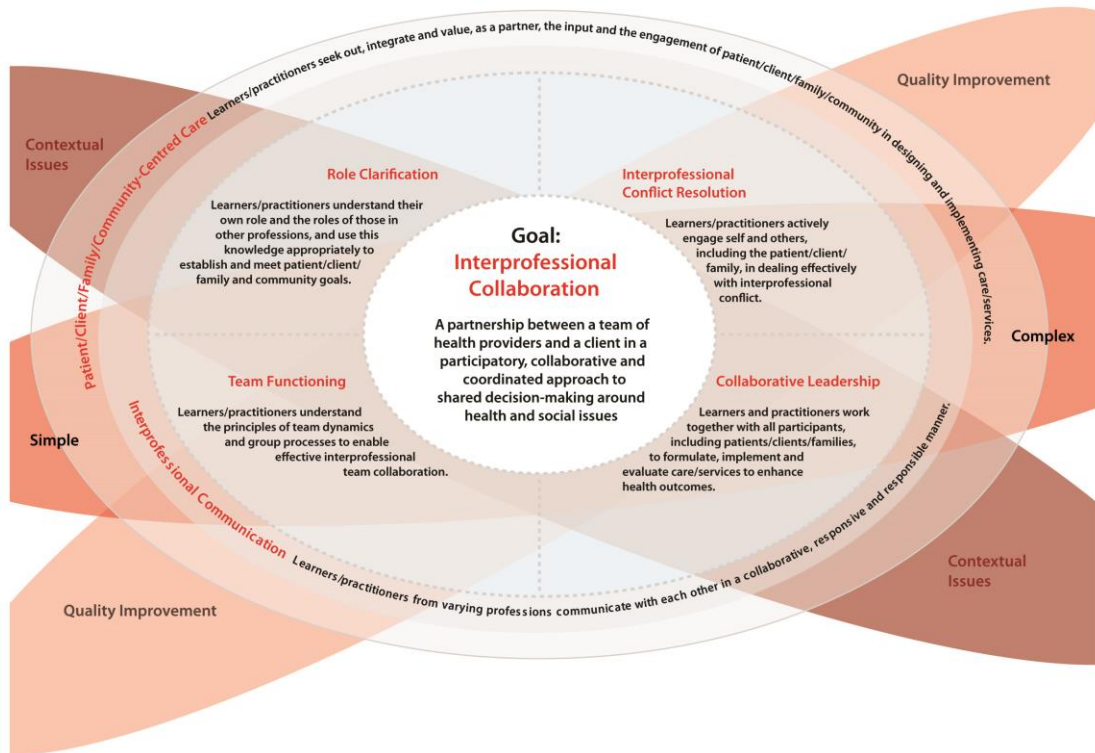
*Reprinted with permission from the Canadian Interprofessional Health Collaborative

     The figure above outlines the placement of the six competencies and what the CIHC terms' background considerations that influence how the competencies may be applied in different contexts. The concept of simple to complex is used to describe that the need for multiple health care providers will vary from two to many, depending on the particular situation at hand. Contextual issues, refer to the practice area, recognizing that the nature of interprofessional collaboration will vary depending on the context. Finally, quality improvement describes carrying out these activities in interprofessional teams rather than within individual professional groups. A complete description of these competencies may be found in Table 1.

Table 1: Interprofessional Competency Descriptions (CIHC, 2010)

Competency	Descriptor
Patient/Client/Family/Community Centred care	Practitioners seek out, integrate and value, as a partner, the input and the engagement of patient/client/family in designing and implementing care/services.
Interprofessional Communication	Practitioners from varying professions communicate with each other in a collaborative, responsive and responsible manner.
Role Clarification	Practitioners understand their own role and those in other professions, and use this knowledge appropriately to establish and meet patient/client/family and community goals.
Team Functioning	Practitioners understand the principles of team dynamics and group processes to enable effective interprofessional team collaboration.
Interprofessional Conflict Resolution	Practitioners actively engage self and others, including the patient/client/family, in dealing effectively with interprofessional conflict.
Collaborative Leadership	Practitioners work together with all participants, including patients/clients/families, to formulate, implement and evaluate care/services to enhance health outcomes.

As compared to the other competency documents, the Canadian document includes an emphasis on conflict resolution and shared leadership. While the other documents include these competencies, they are not named as one of the overall domains.

Even when professionals possess the competencies for collaborative practice, the quality of the collaboration is impacted by multiple factors at the interpersonal, program, and systems levels (Bourgeault & Mulvale, 2006; D'Amour & Oandasan, 2005; San Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005). At all of these levels, interprofessional collaboration requires a non-competitive stance between professionals and between health care institutions (San Martin-Rodriguez et al., 2005). These authors stressed that no interprofessional team functions in a vacuum, immune from organization and systemic influences. San Martin-Rodriguez et al. (2005) reviewed the literature and described three levels of interprofessional collaboration determinants: interactional or micro, organizational or meso, and systemic or macro determinants, which are those elements outside of the organization. Interactional determinants of interprofessional collaboration included: individuals' willingness to collaborate, extent of mutual trust, respect, and interpersonal communication. Organization level determinants included the organizational philosophy, structure, resources, administrative support as well as modes of communication. At a systemic level one must consider the social, cultural, educational and professional systems in which the individuals and the organization are situated within. Interprofessional collaboration also suggests an implied voluntary collaboration that involves negotiation at all three of these levels, the individual, team and institution.

D'Amour & Oandasan (2005) highlight that patient-centredness is central to

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interprofessional collaboration. Patient-centred practice includes partnership between patient and practitioner, respect, choice, empowerment, and patient involvement (Law, M., 1998; Law, Baptiste, and Mills, 1995; McColl & Pranger, 1994;Sumsion, 2000) Stewart, Brown, Weston, McWinney, McWilliam, & Freeman, (2014) discuss patient-centred care in the context of the patient-practitioner relationship and state that includes empowering patients and power sharing in the patient-practitioner relationship, balancing both an objective with a subjective stance that unites the mind and body. These authors discuss the four components of patient-centred clinical method: 1) exploring health, disease, and the illness experience, 2) Understanding the whole person, 3) finding common ground, and 4) enhancing the patient-clinician relationship

      Barriers to interprofessional collaboration: Several authors have noted barriers to interprofessional collaboration that make it difficult to achieve interprofessional collaboration on health care teams. In their review of teamwork throughout the United Kingdom, Borrill et al. (2001) reported that gender, multiple reporting lines, status differences, and a lack of organizational supports make it difficult for team members to work together. Not surprising then, several studies have documented the difficulties experienced when providers are assigned to work together without possessing the requisite collaborative competencies (Atwal & Caldwell, 2006). Suter et al. (2009) found that while communication was a key competency, some of the study participants reported poor communication between providers. Other authors have reported poor conflict resolution skills (Rosenstein & O'Daniel, 2005; Hendel, Fish, & Berger, 2007; Drinka & Clark, 2000), established hierarchy (Payne, 2000; Shaw, DeLusignan, & Rowlands, 2005), and a lack of knowledge of one's own role as well as the roles of others on the

team (Suter et al., 2009). However, the majority of these studies focused on acute care settings.

There is also some evidence suggesting that socialization of individuals into their respective professions may lead to struggles in developing their interprofessional identities (Khalili, Orchard, Laschinger, & Farah, 2013). Baker, Egan-Lee, Martimianakis and Reeves (2011) suggested that groups of professionals claim exclusive ownership of knowledge and expertise in specific areas. Furthermore, professions protect these areas of practice to advance the members' interest; for example, health profession pre-licensure education of physicians may socialize individuals to perceive themselves as leaders. Medical students attempting to formulate their professional identity add "leader" to their developing identity, understanding that this is what they should expect of themselves and part of what is expected of them by others. Khalili et al. (2013) found that medical student study participants were aware that some of their peers believed their professional knowledge and skills were more valuable than those of other professions. This professional identity is in conflict with interprofessionalism. Interestingly, this same study suggested that students of professions other than medicine participate in interprofessional education with their sights on improving their own status. As one learns about his or her chosen profession, it is not unusual that the differences between professions are highlighted. Furthermore, interprofessional approaches may be perceived as a threat to this developing professional identity (Baker et al., 2011) and result in a negative attitude towards other professions (Stull & Blue, 2016). In addition to the emphasis on the professional differences, Khalili et al. (2013) suggested that health care providers need to adopt a dual identity; in addition to developing a professional identity,

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professionals working in today's health care environment also require an interprofessional identity. To develop an interprofessional identity, the providers need to explore misconceptions or stereotypes about other professions as well as the similarities between professionals, highlighting their joint commitment to high quality patient-centred care.*Effectiveness of interprofessional collaboration:* Mickan (2005) reported that teamwork has resulted in reduced hospitalization time and costs, fewer unexpected admissions, increased access and coordination of care. These same researchers report that the team benefits include improved communication, efficient use of services, and professional diversity on the team. Furthermore, team members are more satisfied with their jobs, enjoy greater role clarity and enhanced well-being. Finally, patients have reported improved health outcomes, increased satisfaction with care, and awareness of treatment.

Researchers have reported successful interprofessional collaboration in many areas of health care (Zwarenstein, Goldman, & Reeves, 2009) such as, internal medicine (Miller et al., 2008; Reeves et al., 2007), intensive care (Zwarenstein & Reeves, 2006), rehabilitation (Reeves et al., 2007; Strasser, Falconer, Herrin, Bowen, Stevens, & Uomoto, 2005; Strasser, et al., 2008), mental health (Solberg et al., 2001), geriatric care (Boult et al., 2001; Trivedi et al., 2013) emergency care (Campbell et al., 2001), hip fractures (Naglie et al., 2002), and primary care (Mickan & Rogers 2005; Reeves et al., 2007) to name a few. However, most of these studies were exploratory and did not use methodology that would establish cause and effect. Furthermore, the majority of the studies reviewed did not include control groups.

More stringent reviews of interprofessional collaboration interventions initially

reported a dearth of studies (Zwarenstein, Bryant, Bailie, & Sibthorpe, 1999). However,

authors of more recent reviews have reported some positive impacts. For example,

Zwarenstein and Reeves (2006) conducted a review of interprofessional collaboration

interventions to assess their impact on care. Overall these authors reported several studies

in which interprofessional care interventions were found to positively impact care, while

fewer studies reported no difference between the control and intervention groups.

The most recent Cochrane Review explored randomized control studies of the

effects of practice-based interventions such as interprofessional rounds, interprofessional

meetings and externally facilitated interprofessional audits (Zwarenstein, Goldman, &

Reeves, 2009). These authors noted that while there was an increase in studies that met

the inclusion criteria, a mere five studies were included in their review. Some positive

impact on length of hospital stay was also reported.

Interprofessional Collaboration in Primary Care

In practice, interprofessional collaboration was thought to be the innovation needed to

reform primary care in Canada (Conference Board of Canada, 2012; Harris et al., 2016)

the United States (Harris et al., 2016; Phillips & Bazemore, 2010), United Kingdom and

Australia (Harris et al., 2016), and the Netherlands (Willcox, Lewis, & Burgers, 2011) as

well as elsewhere around the world.

In the late 1990s, primary care in Ontario was expected to provide every patient with

access to "comprehensive family medicine and continuity of care" (Way, Jones, &

Busing, 2000, p. 2). In response to this expectation, the Ontario College of Family

Physicians (OCFP) clarified that if they are to provide comprehensive services they could

not do this alone, but rather require an interprofessional team of providers including nurse practitioners and other health care providers (Jones & Way, 2004; Long, McCann, McKnight, & Bradley, 2004; Marsden & Street, 2004). The WHO reported that with the dramatic increases in the number of patients who present with one or more chronic diseases, primary care would be rendered useless if it were not able to treat these individuals. Interprofessional teams and utilization of health personnel other than physicians was one of the innovations thought necessary to meet this growing health care need (WHO, 2002; Donnelly, Brenchley, Crawford, & Letts, 2013), including increased need for coordination of care (Xyrichis & Lowton, 2008). In Canada, there was a national call for the development of interprofessional collaboration as a key component of primary care renewal in 2002 (Romanow, 2002). Primary care renewal was considered paramount to sustaining the Canadian health care system and the ability to provide the most appropriate care, by the most appropriate providers in the most appropriate setting, resulting in better health at lower cost (Health Canada, 2003; Fooks & Lewis, 2002). In their review of five provincial and three national reports on the future of health care in Canada, Fooks and Lewis (2002) identified that there was a strong desire for interprofessional teams beyond the physician and nurse. Thus, the focus turned to interprofessional collaboration in primary care and was aimed at changing this system within Canada and the across the world (WHO, 2010). Throughout the 1980s and 1990s, the UK developed primary care teams of health care professionals that reported better health outcomes and more satisfied staff (Pouton & West, 1999). However, some of these studies also included concerns about a lack of: team democracy, co-location, joint

learning, as well as differences in education, status, and assertiveness and an assumption of the physician as the leader.

More recently researchers have explored the impact of interprofessional collaboration in primary care settings. Interprofessional collaboration has increased accessibility, coordination and comprehensiveness of care, and patient knowledge (Brown, Ryan, & Thorpe, 2016; Hutchison, Levesque, Strumpf & coyle, 2011). While Brown, Ryan, and Thorpe (2016) reported similar results, these authors furthered our understanding of the impact of interprofessional collaboration by finding that these processes are connected to patient-centred care. For example, the study participants, health care providers from 20 family health care teams reported how greater access to care is related to being patient-centred. More broadly, Harris et al., 2016 explored the impact of primary care interprofessional teams in Canada, Australia, and the United States. While these authors concluded that interprofessional collaboration impact varies, working in teams does impact communication and relationships, scope of practice, conflict, and work satisfaction. However, the authors also note that role change resulted in role confusion and resulting tension in some of the practices. There was also concern about leadership hierarchies reported.

In 2011, the Canadian Foundation of Healthcare Improvement reported on the success of the Vancouver-based Rapid Access to Consultative Expertise (RACE) program where family physicians and nurse practitioners may access specialists in different fields via telephone (CFHI, 2014). While the list of areas is growing, the RACE website (www.raceconnect.ca) currently lists over 20 specialty areas that may be consulted as part of the program including mental health. Recently, the RACE program

reported that almost 80% of their calls from specialists were returned while patients were in the primary care office. Authors of the program evaluation reported that 33% of patients for whom the family physician used RACE avoided a hospital visit and almost 60% of patient did not require a referral for specialist care after the telephone consultation (Kramer, 2013). While these results are impressive, more rigourous studies have not been reported thus far.

Models of interprofessional collaborative primary care in Canada: To increase accessibility, continuity and coordination of care in cross Canada there has been a move to models of care that include groups of providers from different health care education backgrounds. For example, Quebec introduced community services centres in the 1970s that were public versus private funded health and social care centres (Breton, Pineault, Levesque, Roberge, Da Silva, Prud'homme, 2013).. These interprofessional centres included professionals from nursing, occupational therapy, physical therapy, nutrition, psychology, and social work. However due to the funding model used, i.e. salary, few physicians chose to participate in this model of care, More recently developed models of interprofessional collaborative primary care such as, Quebec's Family Medicine Group and Ontario's Family Health Care Team (FHT), have been implemented (CFPC, 2011). Physicians on the FHT were paid through a blended capitation model or a blended salary model (Glazier, Zagorski, & Rayner, 2012). The FHT, included an interprofessional team as well as funding for an executive director, and an electronic medical record (EMR). Family Medicine Groups are privately owned and involve a collaboration between family physicians and nurses who provide services to rostered patients. There teams also include administrative support (Breton et al., 2013).

More recently health authorities created interorganizational collaborations that serve communities such as British Columbia's Integrated Primary Care Centres (British Columbia Ministry of Health, 2015), Alberta's Primary Care Networks and Family Care Clinics (Alberta Health, n.d.), Quebecs' Local Health Networks (Breton et al, 2013), Ontario's Local Integrated Health Networks and Manitoba's Physician Integrated Network (Katz et al., 2016). These interorganizational collaboration are networks such as, Quebec's Local Health Network (Breton, et al., 2013), Ontario's Local Integrated Health Network, and Manitoba's My Health Teams (Katz et al., 2016; Manitoba Health, n.d.). In Manitoba, the primary care networks, collaboration between the regional health authority, fee-for-service FPs and community organizations offer services that *enhance primary care* to meet the specific community needs (Manitoba Health, n.d.). Although there are few research studies, evaluations conducted suggest these models are having a positive impact on patient care (Katz, et al., 2016). Increased access to care, and decreased rates of chronic obstructive pulmonary disorder were reported in London, Ontario (Health Quality Ontario, 2012) as well as improved control of diabetes (Dinh & Bounajm, 2013). In reviewing the provincial and territorial initiatives, most of these primary care teams are physician-led. A few primary care teams are nurse practitioner-led, for example, Manitoba's Quick Care Clinics for minor health concerns. Nurse practitioners have also led teams in underserved regions in Ontario since 2007 and currently serve in 20 Ontario communities (Ontario Ministry of Health and Long-Term Care, 2015).

In a recent study, community-led clinics that serve populations with lower incomes, more newcomers, more severe mental illness and chronic conditions, and higher rates of

morbidity and comorbidity, reported lower than expected levels of emergency department visits (Glazier, Zagorski, & Rayner, 2012). Features of the community health clinics in this study included serving a particular community and a focus on the social determinants of health and health promotion. Another unique characteristic of these community-led clinics included interprofessional teams with all professionals being paid salary versus fee-for-service remuneration (Glazier et al., 2012).

Some jurisdictions have created integrated primary care networks. These networks consist of a core group of health care providers such as physicians and nurses who are connected to organizations and a group of professionals they have access to, but with whom they are not co-located. Primary care networks were created to enable groups of professionals to share resources. Some researchers have reported that early evaluation suggests that the primary care networks hold promise to reduce emergency department visits for those with chronic obstructive pulmonary disorder and improve blood sugar levels in patients with diabetes (Bradley, 2009). However in Ontario, family health networks and family health organizations that see patients with higher incomes and lower rates of chronic disease morbidity and co-morbidity, had higher than expected rates of visits to emergency departments (Glazier et al., 2012).

The Patient's Medical Home (PMH) is an interprofessional collaborative primary care model that has been defined as, "a central hub for the timely provision and coordination of a comprehensive menu of health and medical services patients need" (CFPC, 2011, p.8). Key features of this model of care include: a patient-centred approach including patients as partners in decision making and provision of care, co-located or linked virtually, providers work as a team, relationships between providers and patients

are developed and strengthened over time, and patients' feel comfortable to present health issues (CFPC, 2011).

Facilitators of interprofessional collaborative care in primary care: Across Canada, strategies of primary care renewal include integration of nurse practitioners (NP) into primary care, where they are expected to collaborate with FPs. Similar practices are occurring in many other countries such as England, Australia, and the Netherlands (Willcox et al., 2011). Researchers have been exploring the workings of this NP-FP collaboration for many years in their attempt to provide guidance for these developing collaborative relationships (Way & Jones, 1994; Way, Jones, & Busing, 2000; Way, Jones, & Baskerville, 2001; Way, Jones, Baskerville, & Busing, 2001). One of their projects aimed to develop and evaluate case studies that focused on NP/FP collaborative care. An important knowledge translation activity that resulted from this project was a proposed framework consisting of seven essential elements of collaboration in primary care: 1) cooperation among providers that acknowledged the perspectives of the various providers, 2) assertiveness is thought to be the complement to cooperation by encouraging providers to state their professional opinion, 3) communication with a focus on both what is said and the relationship between providers, 4) coordination of care included ensuring that NPs and FPs created care plans that ensured that the appropriate qualified personnel was providing care, 5) responsibility and accountability included those aspects of care that the NPs and FPs were individually and collectively accountable for within the practice, and when there was a collectively accountability, both NPs and FPs were expected to participate in decision making and be responsible for the outcomes, 6) autonomy is the ability of each provider to make independent decisions and recognizes

that both NPs and FPs are independently regulated autonomous providers who deliver care within their respective scopes of practice, and 7) a trust and respect that is described as the binding agent for all of the other six elements. That is, without respect, the other six elements cannot exist (Way, et al., 2000).

In the context of primary care renewal, a patient-centred approach is the "core value of family medicine" in Canada (College of Family Physicians of Canada [CFPC], 2014, p. I). To assist FPs, the CFPC developed and made available, a number of guides to providing patient-centred care (CFPC, 2014). In a patient-centred approach, patients have an ongoing relationship with a PCP who works with the patient and family, as well an interprofessional team to provide holistic, coordinated care (Epstein, Fiscella, Lesser, & Stange, 2010; Kellerman & Kirk, 2007). Working in partnership with the patient, families, and the other members of the interprofessional health care team is key to patient-centred care (Berwick, 2009; Epstein et al., 2005; Epstein & Street, 2011; Gutkin, 2012; Little et al., 2001; Ishikawa, Hashimoto, & Kiuchi, 2013; Kvale & Bondevik, 2008; Robinson, Callister, Berry, & Dearing, 2008; Stewart et al., 2000). Interprofessional collaboration is a facilitator of patient-centred care and patient-centred care facilitates interprofessional collaboration (CFPC, 2014; Canadian Nurses Association, 2011). Together, patient-centred care and interprofessional collaboration ensures that patients have access to the "right provider at the right time in the right place," (CFPC, 2014, p.6)

Some researchers have reported interprofessional education as a facilitator of collaborative practice. For example, understanding the roles of each health care professional in primary care, a recognized interprofessional collaboration competency

(Akeroyd, Oandasan, Alsaffar, Whitehead, & Lingard, 2009), does not come naturally and must be taught (Soklaridis, Oandasan, & Kimpton, 2007). These authors also reported that professionals require post-licensure interprofessional education to learn about collaborative processes. D'Amour and Oandasan (2005) and the WHO (2010) make a strong link between interprofessional education and interprofessional practice, suggesting that interprofessional collaborative practice cannot be developed and sustained without the accompanying education.

Similar to other areas of collaborative practice, role clarity and understanding team members' scope of practice is thought to contribute positively to interprofessional collaborative primary care (Bailey, Jones, & Way, 2005; Goldman, Meuser, Rogers, Lawrie, & Reeves, 2010; Soklaridis et al., 2007). When team members understand their own role as well as the roles of others, they will attribute differences to the person or role constraints rather than to a team member's problem personality, thus avoiding emotional conflicts (Rentsch & Zelno, 2003) However, Paul and Peterson (2001) pointed out that in order to have role clarity there must be clear role expectations and boundaries. Clarifying each team member's role may reduce misunderstandings and confusion amongst team members.

Bailey et al. (2006) explored nurse practitioners' and family physicians' stories of collaboration. In their qualitative study, they were interested in documenting the nature of the interprofessional collaborative relationships between NPs and FPs in primary care. They interviewed NPs (n=5) and FPs (n=13) before and after an educational intervention. They analyzed 500 stories of collaboration and reported four themes: scope of NP practice, competence of NPs' work, perceived control NPs and FPs had over their

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practices, and the place of health promotion and disease prevention in the providers'

practice. Beyond these themes, the researchers found that there was little change in the

providers' stories pre- and post-educational intervention. The change researchers reported

was only for those providers that discussed the issues of collaboration and then developed

a model of collaborative practice for their specific practice.

While many authors have reported the importance of shared objectives as an indicator

of collaboration, few have studied this area in detail. In an early study, West and Poulton

(1997) used the Team Climate Inventory to measure objectives, participation, task

orientation and support for innovation as indicators of team functioning. These authors

compared the results of primary care teams with other teams such as social services

teams, community mental health teams, an oil company management team, and the

National Health Services management teams. The primary care teams scored

significantly lower on all four indicators as compared to the other teams. Further to this,

the authors found that shared objectives, participation, quality emphasis and support for

innovation rather than team size, team tenure and general practitioner fund-holding (i.e., a

UK term for when primary care practices receive a budget to purchase health care

services on behalf of the patients) predicted team effectiveness. As well, teams that had

high levels of participation and collaboration were more apt to achieve patient-centred

care. West and Poulton (1997), reported that shared objectives had largest impact on team

effectiveness. Similarly, Borrill et al. (2001) reported that when team members have a

vision that has been co-constructed by team members as opposed to individuals having a

unique vision, collaboration is enhanced. According to these authors, the physical

practice environment may increase or decrease opportunity for team members to be in contact with one another and build relationships.

The role of a team manager or executive director is also thought to make a positive contribution to collaborative care in primary care settings by providing overall team practice management and team development (Goldman et al., 2010). These same authors suggest that positive physician role modeling is an important factor when trying to encourage the transition to team-based primary care delivery. Team meetings, case conferences and use of a common EMR, are often reported as key facilitators of collaborative practice (Goldman et al., 2010).

Effective interprofessional relationships between team members are foundational to interprofessional collaboration in primary care (CFPC, 2014; Poulton & West, 1999). Pullon (2009) explored the relationships between doctors and nurses working in primary care in New Zealand and found that within particular nurse-doctoral dyads there was perceived mutual trust and respect that was underpinned by a clear professional identity. The health care providers' in this study had a clear understanding of their professional identity and an understanding of each other's professional identity. The individual's strong professional identity led to his or her sense of individual competence. As individual health providers demonstrated their competence, they became credible to the other professional, contributing to the development of mutual respect and trust. Pullon (2009) suggested that building a trusting and respecting relationship requires time and occurs sequentially i.e., establishing one's professional identity enables the individual to demonstrate competence that then leads to mutual respect, that leads to mutual trust.

Way, Jones, and Busing (2000) also highlight mutual respect and trust as skills required for interprofessional collaboration in primary care.

       Barriers to interprofessional collaborative care in primary care: Several researchers have reported common barriers to teamwork in primary care settings including, hierarchy, different philosophical approaches to care, and remuneration models (Brown et al., 2011; Dobson et al., 2006; Hutchison, Leveque, Strumpf, & Coyle, 2011). Goldman et al. (2010) also reported challenges NPs and pharmacists experienced defining their roles and educating other team members about their areas of expertise. Few studies have explored team conflict on primary care teams. Some authors have stressed that on primary health care teams where patient care is complex and dependent on contributions from multiple care providers, the potential for conflict is great (Drinka & Clark, 2000). Brown, Lewis, Stewart, Freeman and Kaperski (2011) described how conflict may occur at the micro, meso and macro levels. These authors identify that the physical space, personality clashes, and lack of clarity about scopes of practice may contribute to conflict at a micro level. More external factors such as patient volume, provider remuneration and patient expectations may create opportunity for conflict at a the meso or macro level. Brown, et al. (2011) explored experiences of conflict on the interprofessional primary care team. These researchers included participants from Ontario's family health groups, family health networks, community health clinics, and family practice teaching units to ensure maximum variation of the sample. Findings of the study included three sources of conflict: role boundary, lack of understanding of scope of practice, and accountability. The authors also found that time, workload, hierarchy, lack of recognition or motivation to address conflict as well as concern about

creating emotional discomfort for others were all reasons why team members avoided

conflict (Brown et al., 2011).

Co-location of providers is thought to encourage collaborative care while

separation of providers is perceived to negatively impact team development (Goldman et

al., 2010). When providers are not co-located, there is an inability to naturally develop

relationships through informal or impromptu meetings. Researchers have suggested that

the use of space is an important consideration when wanting to encourage

interprofessional collaboration (Pottie et al., 2008; Price et al., 2009).

Outcomes of interprofessional collaboration in primary care: Interprofessional

teams have been effective when working with patients with chronic conditions in primary

care (Wagner, 2000). In Canada, interprofessional teams have been shown to be

successful at improving outcomes for some chronic conditions such as diabetes and

depression (Conference Board of Canada, 2013). In the Canadian Survey of Experiences

with Primary Health Care (CSE-PHC), Statistics Canada (2009) reported that Canadians

who had access to an interprofessional care team received increased health promotion,

disease prevention and greater continuity of care. Goldman et al. (2011) reported that

health care providers in their study perceived that providers have made gains in

collaborative care and believed that collaborative care was increasing the focus on

collaborative patient-centred care. For example, these researchers found that a key

outcome of interprofessional collaborative primary care allowed FPs to spend more time

seeing patients who required their expertise (Goldman et al., 2011).

While there is a growing body of knowledge about interprofessional collaboration

within primary care, most studies are exploratory with few studies establishing

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effectiveness (Craven & Bland, 2006). Of those studies that do focus on establishing outcomes, there is some support for the effectiveness of interprofessional teams in terms of providing quality care, increased patient and provider satisfaction, and reducing emergency department visits.

Collaborative Mental Health Care in Primary Care

Historically, access to mental health care has been poor for individuals needing care. Researchers have reported fewer than 25% of those individuals with a mental illness received care from a specialist (Hickie, Groom, McGorry, Davenport & Luscombe, 2005). A report by Rhodes, Bethell, and Schultz (2006) stated that 50% of individuals seeking health services for depression in Ontario did not have contact with a mental health specialist. However, 73% of those with depression had contact with a FP, and of these individuals, 31% received treatment from a FP only. Thus, most patients with a mental disorder seek treatment in a primary care setting.

FPs commonly treat individuals with mental illness, with depression being the most often reported illness (Collins, Wolfe, Fisman, DePace, & Steele, 2006). Rhodes et al. (2006) highlighted depression as a chronic condition that may be effectively treated in primary care settings while other authors have suggested that FPs are not always comfortable working with individuals with depression (Anthony et al.,2010; Benzeret al., 2012;Fickel, Parker, Yano, & Kirchner, 2007; Henke, Chou, Chanin, Zides, & Scholle, 2008). Furthermore, the ability of FPs to detect depression in those who meet the diagnostic criteria has been inconsistent (Collins et al., 2006; Rhodes, et al., 2006). Researchers have also reported that PCPs do not always feel comfortable prescribing medications that are indicated for those with depression (Swenson et al., 2009). FPs have

raised concern that patients with mental health issues require more time (Collins et al., 2006) and do not fit into the 10-15 minute primary care appointment time, often requiring more time for counselling and support (Ostbye et al., 2005; Rhodes et al., 2006; Younes et al., 2005). In a survey study about FPs experiences with 1519 patients with mental health problems, Younes et al. (2005) found that in addition to requiring more time, the FPs also reported that these individuals required frequent consultations, and were difficult to refer.

Although some of the barriers to primary mental health care are FP comfort, knowledge, skills, and time, there is also a history of poor collaborative relationships amongst psychiatrists and family physicians (Craven et al., 1997; Kates, Lesser, Dawson, & Devine, 1987; Younes et al., 2005). Early research on the consultative relationship indicated that FPs and psychiatrists have had long standing struggles. While psychiatrists complained about poor FP referral letters (Blakey, Morgan, & Anderson, 1997) and disagreement with FP's patient assessments (Hampson et al., 1996), FPs reported low levels of referral follow-up information being sent, especially for missed follow-up appointments (Cummins, Smith, & Inui, 1980; Hampson et al., 1996), not receiving information requested, such as an indication of suicide risk (Williams & Wallace, 1974), consultation reports being of limited educational value, and excessive wait times to receive consultation reports (Killaspy, Banerjee, King, & Lloyd, 1999; Williams & Wallace, 1974).

In response to these barriers and with a goal to increase access to primary mental health care, mental health reform was beginning to take root in Canada (Kates, Craven, Bishop et al., 1997). In the context of mental health reform, Kates, Craven, and Bishop et

al. (1997) introduced Canada to Shared or Collaborative Mental Health Care (CMHC). This type of collaborative care was jointly introduced by the Canadian Psychiatric Association and Canadian College of Family Physicians. These two groups jointly proposed a partnership between family physicians and psychiatrists that was focused on improving collaborative communication building partnerships, and integrating psychiatrists into primary care settings. The aim of this partnership was to increase access to mental health care. A similar joint effort approach between psychiatry and family medicine was emerging in other countries such as, the United States (Katon et al., 1995).

In addition to increasing access to mental health care, CMHC was being proposed to address service fragmentation, and better use of resources in an environment with scarce resources (Kates, Craven, Bishop et al., 1997; Kates, Craven, Crustolo et al., 1997; Kates et al., 1987; Williams & Wallace, 1974). It was thought that if FPs and mental health providers worked together, mental health patients' would have increased opportunity to receive timely and appropriate mental health care in a familiar setting (Kates et al., 1997; Rockman et al., 2004).

Initially, small demonstration projects provided emerging support for CMHC improving access to mental health services in primary care (Goossen, Staley, & Pearson, 2009; Kates, Craven, Crustolo et al., 1997; Swenson, et al., 2009). For example, Kates, Craven, and Crustolo et al. (1997) explored provider satisfaction after implementing a CMHC program where psychiatrists were located in a primary care office and provided consultation, follow-up, consultation for patients not seen, and education. Results of this study indicated providers were very satisfied, rating the experience at 4.6/5. Reported benefits of co-locating psychiatrists into primary care offices included increased access to

psychiatric consultation, enhanced continuity of care, increased support for the FP, improved communication between providers, an increase in providers' knowledge of each other, improved utilization of mental health services, FP education, and enhanced opportunity for medical residents to learn about collaborative practice.

Researchers exploring CMHC began to identify broad elements critical to program success such as, communication and personal contact (Clatney, Macdonald, & Shah, 2008; Farrar, Kates, Crustolo, & Nikolaou 2001). Others explored the effectiveness of collaborative care and reported that it was essential to have a case manager who followed up with patients to ensure adherence to treatment and medication regimes (Gilbody, Whitty, Grimshaw, & Thomas, 2003; Katon, Von Korff, Lin, & Simon, 2001; Von Korff & Goldberg, 2001).

Co-location has consistently been identified as an important factor in building collaborative teams between healthcare specialists in mental health and those generalists in primary care (Craven & Bland, 2006; Goossen et al., 2012; Mulvale, Danner, & Pasic, 2009). Moreover, collaborative mental health teams that include interprofessional face-to-face case conferences increase interaction and interprofessional collaboration by team members (Mulvale, Danner, & Pasic, 2008).

In a case study of ten Ontario family health care teams, Mulvale, Danner and Pasic (2009) found that team factors affecting collaboration included a physician-as-leader approach versus a team-based approach, respect for professional differences in culture and practice style, a common team vision, and communication. A non-hierarchical relationship was found to be a pre-requisite to establishing open communication between the individuals and within the team as a whole (Mulvale et al.,

2009). While hierarchy was seen to be an enduring problem by some team members, others believed that the physicians would come to accept them over time.

In 2006, Craven and Bland conducted a systematic review of experimental research to understand best practices in CMHC. The majority of the studies reviewed, focused on collaborative treatment for individuals with depression. The authors reported that collaborative care that used treatment guidelines for depression and provided follow-up care was effective. Craven and Bland also noted that patient education provided by non-PCPs improved outcomes. These authors also concluded that collaboration amongst providers developed most fully when providers are co-located and build on existing relationships. However, creating these relationships required time, preparation and supporting structures to impact patient outcomes. This review also concluded that when CMHC interventions were part of a research project, it was difficult to sustain the collaborative care once funding ceased.

Another important contributor to the efforts of CMHC in Canada was the Canadian Collaborative Mental Health Initiative. Beginning in 2004, this initiative supported by the Primary Health Care Transition Fund, developed and then produced evidence-based research to support further development of CMHC (Gagne, 2005). Moreover, the initiative increased awareness of collaborative mental health care, engaged many national professional associations, consumers and families, developed and widely disseminated evidence-based resources ensuring that this information was free to all interested parties, and created a plan for sustainability. Key to the work of the initiative was that the definition of collaborative care be broadened to include a patient-centred approach.

In addition to provider collaboration, patient-centred care that assumes collaboration of all providers with patients is thought to improve outcomes in primary mental health care (Lewin, Skea, Entwistle, Zwarenstein, & Dick, 2001; Orchard, Curran, & Kabene, 2005). Patient-centred care is about collaboration that recognizes the uniqueness of each patient and the importance of treating individuals holistically (Lewin et al., 2001). There is an emerging body of literature that supports collaborative patient-centred care for depression (Katon et al., 2010; Lewin et al., 2001). In a recent review, 11 studies of patient-centred practice examined patient satisfaction and six of these studies demonstrated increased patient satisfaction by those who received a patient-centred practice intervention (Lewin et al., 2001). Interestingly, this literature also revealed that when a team's focus is on disease management rather than the person, communication breakdown between all providers is more frequent (Lewin et al., 2001).

In 2011, when Kates et al., on behalf of the Canadian Psychiatric Association and the College of Family Physicians of Canada, released their second joint position paper, it was clear that CMHC had evolved and included an interprofessional team made up of a variety of professionals including nurse practitioners and counsellors (Swenson et al., 2009). At the same time, the updated position statement proposed the following definition of CMHC, "primary health care delivered by providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual support" (Kates et al., 2011, p.2). The authors noted that this definition is supported by providers having common goals and ongoing communication and is underpinned by the following principals of CMHC:

1. Built on personal contacts.

2. Based on mutual respect, trust, and recognition of each partner's potential roles and contributions.

3. Based on effective practices that are evidence- and experience-based.

4. Responsive to the changing needs of patients, their families, other caregivers, and resource availability.

5. Shaped by the context and culture in which care takes place.

6. Relevant and responsive to local resource availability, and the skills and interests of participating partners (Kates et al., 2011, p. 3).

The position paper also reported on consensus being reached about the components that contribute to an effective CMHC program (Kates et al. 2011). For example, most programs include: a case manager, psychiatric consultation and brief forms of counselling (cognitive behavioural, motivational interviewing or interpersonal), patient education, access to resources, and screening for depression and anxiety (Kates et al., 2011). However, Kates et al. (2011) suggested that while these elements are essential, they must be built upon an understanding of the PCP's need for collaboration and strong collaborative interprofessional relationships (Goossen et al., 2012; Paquette-Warren, Vingilis, Greenslade, & Newnam, 2006).

Today, some CMHC programs are specifically aimed at those individuals who suffer common mental disorders such as anxiety and depression, both of which are considered chronic diseases that result in great burden for the individual, family, community and health care system (Chisholm et al., 2016). A recent Cochrane review of 79 randomized controlled studies found strong support for collaborative care for depression and anxiety (Archer et al., 2012). These same authors reported that patients

were more satisfied with collaborative care as compared to treatment as usual and providers adhered to prescription guidelines more closely. In conducting this review, Archer et al. (2012) defined collaborative mental health care by four features: 1) multi-professional approach, 2) treatment was evidence-based management including the use of protocols, 3) scheduled follow-up appointments, and 4) enhanced interprofessional communication.

Summary of the Literature Review

Interprofessional collaboration where teams of health care professionals work together to ensure high quality health care holds promise to benefit patients and providers as well as the health care system. Providers from all health care backgrounds must become competent in interprofessional collaboration, in addition to their profession specific and shared interprofessional knowledge and skills. More specifically, to be able to practice interprofessionally, health care providers must be competent in role clarification, team functioning, interprofessional conflict resolution, collaborative leadership, patient/client/family/community-centred care, and interprofessional communication (CIHC, 2010).

Interprofessional collaboration is thought to be critical to meet the health care needs of patients seen in primary care settings (Xyrichis & Lowton, 2008). Increasingly patients seen in primary care present with more than one chronic illness that requires that they access the services of more than one health care professional. Researchers have identified specific elements of collaboration in primary care (Way, Jones, Baskerville, & Jones, 2001) as well as barriers to interprofessional collaboration (Molyneux, 2001).

Smith, Allwright, and O'Doud (2007) conducted a review of the effectiveness of interprofessional collaboration interventions used in the treatment of chronic conditions. This review specifically reviewed the collaboration between primary care providers and specialty physicians. The vast majority 19 out of 20 studies included in this review were randomized control studies and eight of the 20 studies reported mental health outcomes. These authors concluded that there are an increased number of studies examining CMHC, however, the numbers remain quite low and the design flaws are significant (Smith, Allwright, & O'Doud, 2007).

The patients seen in CMHC programs have improved access to mental health consultation services and report receiving quality mental health services. Collaborative working relationships have increased primary care physicians' comfort and skill in delivering mental health services in primary care, resulting in an increase of effective use of available resources. Most studies exploring CMHC use a quantitative approach with a propensity towards survey methods (Craven & Bland, 2006). To date, studies have focused on satisfaction of family physicians, psychiatrists and patients, illuminating significant differences between groups and gleaning percentages of care providers who are satisfied or dissatisfied with the collaborative relationships between primary care and mental health services. However, Kuehn (2013) stresses that interprofessional collaboration is a dynamic process that requires relationship building.

To date, there is little research that describes how providers develop and maintain their relationships. For example Farrar et al. (2001) identified that providers were satisfied with each other's expertise but did not detail what aspects of the provider expertise were valued, and by whom. Researchers have identified the important factors

such as open communication, mutual trust and respect between the professionals, but the pathway to these factors remains is elusive. A study that detailed the experiences of the health care providers who work together to deliver mental health care in primary care settings, was needed. As the literature identifies the importance of the interprofessional relationship as foundational to collaboration, this study explored how this relationship develops. Exploring the interprofessional collaborative relationship included provider's need for consultation from mental health specialists, the influences of the individual, provider group, and program leaders on the inter-provider relationships, and the opportunities and challenges for interprofessional collaboration. Thus far, studies examining CMHC provide a general overview of the issues in terms of what is occurring in the field, but they do not yield a model of interprofessional collaboration that may guide practice or inform policies.

CHAPTER 3: INTRODUCTION TO EPISTEMOLOGY, THEORETICAL PERSPECTIVE, AND STUDY DESIGN

To ensure that a proposed study design is aligned with the research questions, Crotty (1998) suggests a scaffolding process. The premise of Crotty's scaffolding process is that researchers often move quickly from creating research questions to deciding on methods of data collection, risking misalignment between collection tools and research questions (Crotty, 1998). Crotty suggests that there are several decision-points between selecting the research questions and establishing data collection methods including consideration of the epistemological stance, theoretical perspective, and methodology. Chapter 4 is a manuscript that describes this scaffolding process as it applies to the current study, Collaborating in the Context of Co-location. The included manuscript shares the decisions made to create the research design that is presented in Chapter 5. This scaffolding decision-making process encouraged the student researcher to engage in a systematic approach to designing this study by guiding the researcher to first consider various epistemologies including objectivism, constructionism, and subjectivism. Once the epistemology was selected, the student researcher went onto consider theoretical perspectives that may inform the study. Theoretical perspectives help the student researcher to consider different aspects of the research design while guiding the data collection, methods, and analysis (Reeves, Albert, Kuper, & Hodges, 2008). The theoretical framework of symbolic interaction provided guidance towards selecting a qualitative approach, as the student researcher was interested in collecting and analysing the multiple perspectives of health care team members. Moreover, the student researcher was interested in gaining an understanding of interprofessional collaboration from expert informants, the health care providers. As the student researcher was interested in

understanding group behaviour of the interprofessional team, a second theoretical perspective was needed to guide this area of interest. The student researcher used the theoretical perspective of social psychology, specifically small group theory, to enable the researcher to attend to the interactions amongst team members. Grounding the study in an epistemology and theoretical perspectives positioned the researcher to select a methodology and methods that aligned best with the study question.

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CHAPTER 4: USE OF A QUALITATIVE METHODOLOGICAL SCAFFOLDING PROCESS TO DESIGN ROBUST INTERPROFESSIONAL STUDIES

Abstract

Increasingly, researchers are using qualitative methodology to study interprofessional collaboration (IPC). With this increase in use, there seems to be an appreciation for how qualitative studies allow us to understand the unique individual or group experience in more detail and form a basis for policy change and innovative interventions. Furthermore, there is an increased understanding of the potential of studying new or emerging phenomena qualitatively to inform further large-scale studies. Although there is a current trend toward greater acceptance of the value of qualitative studies describing the experiences of IPC, these studies are mostly descriptive in nature. Applying a process suggested by Crotty (1998) may encourage researchers to consider the value in situating research questions within a broader theoretical framework that will inform the overall research approach including methodology and methods. This paper describes the application of a process to a research project and then illustrates how this process encouraged iterative cycles of thinking and doing. The authors describe each step of the process, share decision-making points, as well as suggest an additional step to the process. Applying this approach to selecting data collection methods may serve to guide and support the qualitative researcher in creating a well-designed study approach.

Introduction

Health human resource strategists and those concerned with the reduction in medical errors have made significant financial and human investments in increasing interprofessional collaboration (IPC) (San Martin Rodriquez, Beaulieu, D'Amour, & Ferrada-Videla, 2005; Weinberg, Cooney-Miner, Perloff, Babington, & Avgar, 2011), the process whereby health and social professionals work together for the benefit of patient care (Zwarenstein, Goldman, & Reeves, 2009). Many researchers, policy-makers and healthcare professionals consider IPC a critical component to improve the health system and ensure its sustainability for the future (Baggs & Schmidt, 1997; Clarke & Mass, 1998; Leipzig et al., 2002; Lemieux-Charles & McGuire, 2006; Reeves et al., 2009a; Rose, 2011; Sexton et al., 2006). During the last decade, IPC has received increased attention within the literature (Bainbridge, 2008). Given the increase in the number of studies that focus on IPC, it is not surprising that there has also been an increase in the number of systematic reviews on this topic. Cochrane reviews examined how IPC affects professional practice and healthcare outcomes (Reeves et al., 2009a; Zwarenstein et al., 2009). Zwarenstein and colleagues (2009) discussed IPC, noting that current research is not rigourous enough to claim that IPC positively influences professional practice or leads to better health outcomes. However, the authors of both of these Cochrane reviews and others state that qualitative studies are required to further our conception of IPC. Zwarenstein & Reeves (2006) discuss that qualitative studies are important to deepen our understanding about the processes of IPC.

Subsequently, many researchers have embarked on qualitative studies to fill this gap in the literature (Alavi, Irajpour, Abdoli, & SaberiZafarghandi, 2012; Martin & Finn,

2011; McDonald, Jayasuriya, & Harris, 2012). A recent review of the IPC literature reveals a substantial number of qualitative studies that make an important and foundational contribution to our understanding of IPC (Reeves et al., 2009b). For example, Shaw, DeLusignan and Rowlands (2005) conducted a qualitative study that discussed hierarchy as a core barrier to IPC and Piquette, Reeves and Leblanc (2009) described how interprofessional discourse changed over the course of a medical crisis. Hammick (2000), in her review of interprofessional education, states that equal consideration to both qualitative and quantitative studies is important given the use of qualitative studies in the field.

Although some researchers share their application of particular methodologies such as case study (Baxter & Brumfitt, 2008; McDonald et al., 2012), ethnography (Reeves et al., 2009b) or grounded theory (Baggs & Schmitt, 1997), the vast majority of studies are descriptive, lack conceptual or thematic renderings of data and do not identify a particular qualitative approach. Adding to the lack of clarity about methodology, some authors use the terms methods and methodology interchangeably. However, as Crotty (1998) reinforces, methods are the techniques used to gather and analyze data, whereas methodology is the plan of action or process that governs the choice and use of particular methods. In addition to a lack of clarity about methodology, many qualitative studies reported in the literature include the research objectives and data collection methods; however, a conceptual framework is rarely included (Creswell, 2003; Reeves, Albert, Kuper, & Hodges, 2008).

Today, there are many qualitative research textbooks and other resources that researchers can use to inform their research. Many of these resources approach the

qualitative research process as a stepwise method where the researcher works through a series of specific action steps. However, Crotty (1998) contends that researchers often move from the research questions to choosing data collection methods without considering the consequences of their choice. Instead, he encourages a different approach to research design that engages the researcher to consider the focus of study from a broader theoretical perspective. Crotty (1998) emphasizes the thinking process of how to choose methods that will best fit the specific purpose of a given study. To align the research questions to the data collection methods, he suggests a scaffolding approach where the researcher carefully considers the epistemology, theoretical perspectives and methodology that will underpin and frame a specific study. Answering the questions about methods, methodology, theoretical perspective and epistemology are the basic elements of any research process (Crotty, 1998). Proceeding to use data collection methods without exploration of the alignment of the epistemology, theoretical perspectives and methodology may result in a mismatch of the research questions and the data collection methods.

The purpose of this paper was to describe the scaffolding process proposed by Crotty (1998) in the context of designing IPC research. To illustrate this process, the authors describe and discuss the decisions made in developing IPC study they conducted. The overall premise of this paper is that by applying a systematic and thoughtful process, which grounds the selection of data collection method in a congruent epistemology, theoretical perspective and methodology, the researcher will choose methods that match the research objectives. In addition to grounding the data collection method in this five-step process, we offer an additional step for consideration. After selecting the data

collection methods, returning to the theory may elucidate pragmatic issues associated with the selected data collection method.

Step 1: Development of research objectives

First, the researcher identifies a research question that needs to be answered. In this example, the research question was defined as follows: What is the IPC process used to deliver mental health services in primary care in the context of a Shared Mental Health Care program? For this study, we defined that IPC is a process where two or more health professionals work together to make a positive impact on the healthcare of patients (Zwarenstein et al., 2009). The Shared Mental Health Care is a regional health authority program where primary care providers have direct access to mental health counselors and psychiatrists to deliver mental health services in primary care.

To initiate any study process, one identifies the specific research questions or objectives (Crotty, 1998). In this example study, the research objectives were as follows:

1. To detail the need for IPC in the delivery of mental health services in primary care from the perspective of the primary healthcare providers.

2. To detail primary healthcare providers and mental healthcare providers experiences and perspectives of IPC in the context of a primary care program, Shared Mental Health Care program.

3. To identify how the individual, team and group dynamics and system influence the IPC process in the context of the Shared Mental Health Care program.

4. To identify the opportunities and challenges of IPC in the context of the Shared Mental Health Care program.

Once the study objectives are articulated, the researcher may be inclined to

proceed from the objectives to selecting the data collection methods. However, Crotty (1998) suggests resisting the impulse to jump to the methods, and instead encourages researchers to delay study initiation in order to understand the context for the methodology. According to Crotty (1998), a research path can be created that meets the needs of any study question. He suggests that the research question be situated in an epistemology, then theoretical perspective, followed by a choice of method (see Figure 1). Using a scaffolding process to consider and create the research design that is transparent and can be subjected to peer review is what defines research (Creswell, 2003; Schwandt, 2007).

Step 2: Exploring epistemology

Crotty (1998) suggests that once there are research objectives, the next step is to situate the research question in an epistemology that fits the research through which questions. Considering the example study objectives, we explored three ways one acquires knowledge or epistemology: objectivism, subjectivism and constructionism (Crotty, 1998).

The epistemological view of objectivism posits that "truth and meaning reside in objects independent of any consciousness" (Crotty, 1998, p. 42). Objectivists believe that knowledge is discovered and that carefully controlled research can obtain the accurate truth. This epistemology is aligned with a positivist approach to research, where the

Figure 1. Crotty's steps in designing a research path (1998, p.4)
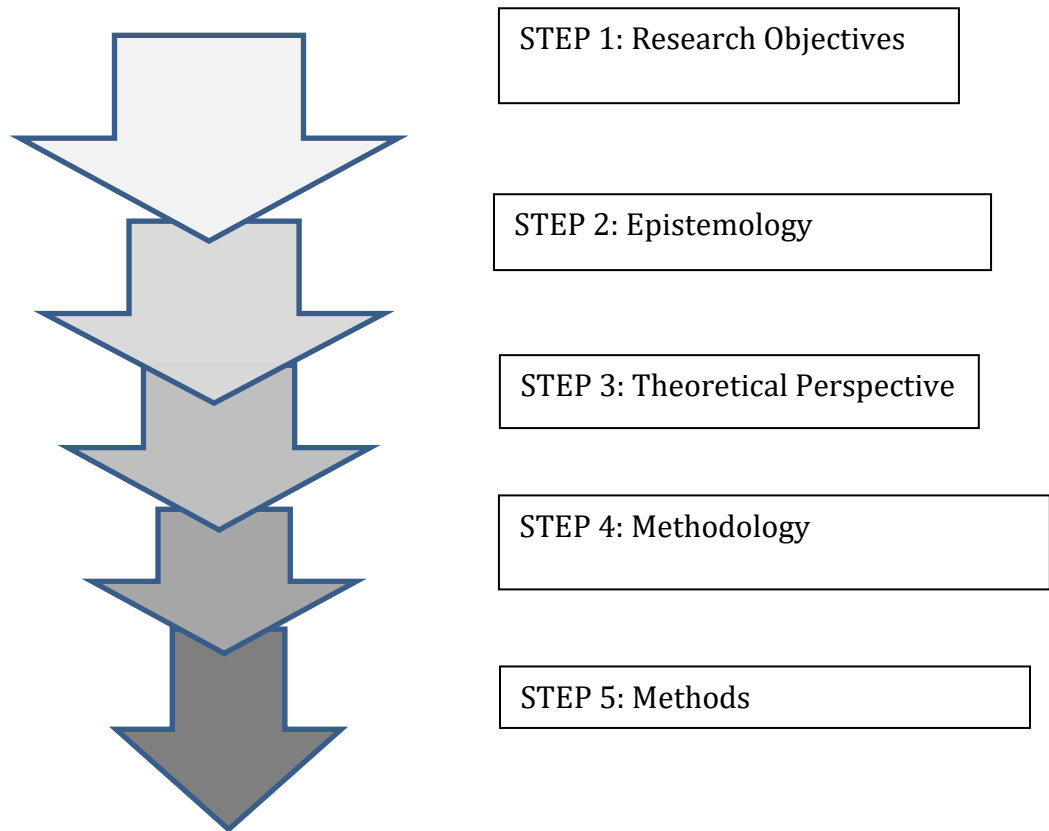
Figure 1. Crotty's steps in designing a research path (republished with permission of Sage publications, from The Foundations of Social Research: Meaning and perspective in the research process, Michael Crotty, 1998; permission conveyed through Copyright Clearance Center, Inc.).

the researcher sets out to prove or disprove a hypothesis. A second epistemology, subjectivism, posits that knowledge is developed through interpretation and that it is only when a subject ascribes meaning to an object that it exists (Schwandt, 2007). A third epistemology, constructionism, contends that reality is constructed rather than discovered. More specifically, constructionism emphasizes that humans inter- acting and

interpreting their environments construct reality. This epistemology posits that although the nature of things exists without the person, the meaning of it does not. One constructs their reality through the meaning they ascribe to it (Crotty, 1998).

When one examined these different epistemologies, it became clear to us that constructionism was the most appropriate match for the research questions posed. This example study's main objective is to understand the IPC process, rather than to objectively test a hypothesis about IPC. Moreover, the researcher is interested in how, what and when research participants create and maintain an IPC process as they deliver mental health services. Considering the nature of healthcare teams and recognizing that IPC is a complex, multifaceted process, the idea that meaning is co-constructed by the healthcare providers who may have varying perspectives that are all accurate was a natural fit. For example, in a consultation situation where the family physician has sought the opinion of a psychiatrist regarding a patient's complaint of anxiety, the family physician is more likely to follow-through with the psychiatrist's recommendation if s/he believes in the appropriateness or usefulness of the suggestion.

The aim of the example research project was to understand the IPC rather than to explain it (Crotty, 1998; Creswell, 2003). As little is known about these IPCs in the delivery of mental health services in primary care, this study engaged experts to examine the research questions posed. As such, this research study is best approached from a paradigm that acknowledges that reality is constructed rather than some objective truth. The qualitative paradigm is congruent with the overall aim of this study, and therefore was best suited to achieve findings that are reflective of the study objectives.

Step 3: Exploring theoretical perspectives

Within the fields of health and social care, IPC (Ødegard, 2006) is a multidimensional construct that can be approached from multiple lenses; hence, multiple theoretical perspectives were considered (Reeves et al., 2008). For this particular project, we felt that theoretical underpinnings from the fields of sociology and social psychology branch of psychology (Stewart, Shamdasani, & Rook, 2007) would best address the study's purpose. The sociological perspective of symbolic interaction (Blumer, 1969) is congruent with the belief in multiple realities, asserting that individual realities are formed by the meaning individual's give to interactions and their responses to those ascribed meanings (Prus, 1994). Since individuals ascribe unique meaning to each interaction, multiple realities would be expected (Charmaz, 2006). The belief in multiple realities was a key theoretical belief in this study, as each individual has a unique professional and personal lens through which they perceive the IPC process. Symbolic interactionism allows the researcher to acknowledge the various perspectives of participants, valuing them equally and perceiving them to all be true (Crotty, 1998).

To attain the research objective of understanding IPC, considering group dynamics of the team is essential. Lewin (1943) began the study of groups and is often attributed with coining the term group dynamics to describe what happens between the participants of a group when they are brought together. Group dynamics commonly refers to the group members' interactions (i.e., verbal and nonverbal) and responses to changes in the group climate, norms, structure, roles and development (Beck & Lewis, 2000; Davis, Burlingame, & Layne, 2006; Rutan & Stone, 2001).

The field of social psychology challenges us to consider the influence of group

dynamics on a group or team of individuals (Harvan, Royeen, & Jensen, 2009; Stewart et al., 2007). More specifically, scholars in social psychology examine the impact of group cohesion (Yalom & Leszcz, 2005), group norms (Feldman, 1984), group roles (Benne & Sheats, 1948) and the stages of group development (Tuckman & Jensen, 1977) on the individual participants and the group as-a-whole (Yalom & Lesszcz, 2005). As this example study took place within the Shared Mental Health Care program milieu, it is essential that the impact of these group dynamics be considered as part of the context in which the IPC occurs.

The two theoretical perspectives of sociology and social psychology each contribute to this study. Together these approaches provide a framework for the researcher to consider both the meaning that is derived through social interaction and the influence of the social milieu on the individual and team (Hewitt & Shulman, 2009). Thus, understanding the theoretical perspectives of symbolic interaction and group dynamics and how they underpin the research objectives helped to clarify the study focus and begin to consider research methodology. Furthermore, considering and selecting theories may inform the understanding and interpretation of data during analysis (Reeves et al., 2008).

Step 4: Exploring methodology

Taking into consideration the example study's objectives, the qualitative paradigm, constructionist epistemology and the theoretical perspectives of symbolic interaction and group dynamics, ethnography or grounded theory was appropriate methodological choices. Ethnography and grounded theory share beliefs in multiple realities (Charmaz, 2006; Fetterman, 2009). Although ethnography draws on

anthropology and is concerned with studying a shared group culture, grounded theory is well suited to studying a process (Creswell, 2007). Exploring IPC could be approached using either methodology or perhaps even a blending of the two. This IPC research study prioritized the understanding of the IPC process and model development, rather than the study of interprofessional group culture. Consequently, grounded theory was a useful methodology that fit with the objectives of this study. However, there are several forms of grounded theory. Constructivist grounded theory, whereby the researcher assumes a position of co-creator of the data (Charmaz, 2006) and is explicitly reflexive (Sandelowski & Barroso, 2002) was the methodology of choice of this study.

After exploring the various epistemologies, theoretical perspectives and methodologies, and selecting those that were appropriate for the study, we found that it was necessary to further refine the research aim and objectives. For example, in this study, the overall research purpose was refined to develop a model of IPC within the context of the Shared Mental Health Care program. The research objectives were revised to better direct this overall goal, which are as follows:

(1) To engage with primary care providers to better understand their desire to work in and their experiences of providing mental healthcare in primary care settings.

(2) To engage with primary care providers and mental healthcare providers to gain an understanding of the primary care providers' need for IPC to deliver mental healthcare in primary care settings.

(3) To engage with primary and mental healthcare providers to examine and detail the IPC process in primary care settings, considering the individual, team and system influences.

(4) To explore the opportunities and challenges of IPC in the context of the Shared

Mental Health Care program with the primary and mental healthcare providers.

Key changes to the research objectives included a clearer aim toward model

development, inclusion of the researchers' intention to engage with participants, thereby

acknowledging the role of the participants and researcher in the process grounded theory

development. The revised research objectives aligned closely with constructivist

grounded theory as described by Charmaz (2006), and were thought to be best attained

using the research methods of interview and focus group. To ensure a most detailed and

accurate study outcome, researchers may use a scaffolding approach that reinforces the

iterative nature of research and requires researchers to make refinements as the study

design is developed.

Step 5: Exploring methods

After selecting a constructivist grounded theory approach as described by

Charmaz (2006), framed by symbolic interactionism and group dynamic theory from

social psychology, we considered methods. Although there are many qualitative research

methods to choose from, individual interviews are the most commonly used method

(Patton, 2002). In the example study, individual interviews were selected to collect data

about the primary care providers desire to work in and their experiences of providing

mental healthcare in primary care settings (research objective 1). The individual open-

ended interviews also garnered data about the primary care provider's perception about

the need for IPC to deliver mental health services (research objective 2), the process of

IPC (research objective 3) and the opportunities and challenges of IPC (research

objective 4). However, open-ended individual interviews were not as effectual in

capturing the mental healthcare provider's perception at an individual level. Moreover, individual interviews did not glean information about the influence of the team nor about how group dynamics influence the IPC process (research objectives 3 and 4). Although the individual open-ended interviews did provide some clues about the influence of the system on the IPC process, our understanding was incomplete and required further study.

A likely choice to gather data regarding the healthcare teams' process would be participant observation (Schwandt, 2007). Using participant observation, researchers gain insight into contexts, relationships and behavior as they are occurring in the field (Morgan, 1997). However, for this particular study, participant observation was problematic because the health professionals meet spontaneously face-to-face. In addition, data were collected from many interprofessional teams practicing at several geographical locations and the time available was not sufficient for full immersion into all the practice environments. Even more concerning, the use of participant observation in this study raised complex ethical issues as the study sites were community clinics where in the course of a day, hundreds of patients were entering and leaving. As the participant observation would have included discussions with and about patients, each patient who entered the clinic would need to provide consent, making participant observation a less suitable choice. Bringing team members together in a focus group to gather data about the influences of the individual, team and group dynamics and the system merited exploration. Although focus groups appeared to be the best alternative to meet objectives 3 and 4, one must acknowledge that focus group data are a representation of the experience at a time subsequent to the experience, rather than data that are collected via direct observation in a natural occurring environment. Considering the research

objectives and unique issues related to this example study, the authors chose to use focus groups as a second data collection method.

Focus groups

Warr (2005, p. 201) states that the research potential of focus groups lies in the way the method provides opportunity for group members to present, explain and occasionally defend their positions in a group setting. Using focus groups to collect data that capture the overt and the more subtle aspects of interactions between the members of the interprofessional team was congruous with research objectives 2 and 3 and provided the team the opportunity to discuss the opportunities and challenges of IPC (objective 4). Unique to focus groups is the influence of group dynamics that may push discussions beyond any individual's prepared themes (Warr, 2005). On the other hand, the group dynamics may also negatively impact the focus group by creating a "group think" that can inhibit quieter individuals from expressing their true opinions. Moreover, when focus groups are conducted with pre-existing groups, there is a risk of future rewards and sanctions between team members for what they said or did in the focus group. Thus, groups of acquaintances may work harder to achieve consensus, deemphasize differences and doubts and show more conformity (Leask, Hawe, & Chapman, 2001).

An exploration of some of the key theoretical concepts related to group dynamics is helpful to the focus group facilitator as these forces come into play, e.g., pressure to disclose or not disclose personal impressions. In addition to considering the interview format, understanding group dynamics can inform the focus group questions. In the example study, we used our understanding of group roles and norms when we asked the focus group participants questions about the processes they use to discuss patient care. In

addition, our knowledge of group development and the need to foster cohesion (Yalom & Leszcz, 2005) was particularly helpful when toward the middle of the focus group, we asked questions that encouraged focus group participants to share how power and position influenced decision-making.

Thus, prior to conducting focus groups, it was important to explore a theoretical basis of groups, such as social psychology, to become familiar with group concepts such as norms, roles, cohesion and stages of development. A focus group interviewer, grounded in a group theory, is better positioned within the group to facilitate a participant to articulate his/her unique perspective, or approach topics considered taboo (Helitzer-Allen, Makhambera, & Wangel, 1994). However, this knowledge and understanding of group theory will contribute to the researcher's "context and subjectivity" (Gough, 2003, p. 22) that may impact the qualitative research process including data collection and analysis (Charmaz, 2006). Understanding what the researcher brings to the process contextualizes the project and identifies the researcher as a co-creator of the process (Charmaz, 2006). Although exploration of theoretical perspectives is part of the process, the researcher also assumes a reflexive stance and examines what s/he brings to the research arena (Hesse-Biber, 2007). Strategies to encourage reflexivity include a reflective journal and peer discussions to explore and understand the researcher's stance (Shenton, 2004).

In this example, focus groups were used to gather the healthcare provider group's collective perspective about the IPC process. However, the researcher must consider the impact of bringing individual health professionals who collaborate in their day-to-day work together to discuss their working relationships and processes and consider using

strategies that facilitate the researcher assuming a reflexive stance throughout this process.

Triangulation of methods

Any one qualitative research strategy has its limitations (Shenton, 2004); thus, in addition to individual interviews and focus groups, a researcher may want to consider further triangulation of data collection methods. In this example study, triangulation of methods was used to render a more credible, dependable and confirmable (Shenton, 2004) understanding of IPC in the context of the Shared Mental Health Care program. Based on the findings of the individual interviews and focus groups, the researchers created a guide that was used to review documents about how the healthcare system supports IPC. The program policies and procedures, web pages, job descriptions, minutes of staff meetings and calendars of meetings and educational sessions were reviewed using the guide. The collection of data also occurred at different times, that is, the interviews were conducted first, followed by the focus groups and then finally, the document review. Furthermore, data collected using all three methods occurred at a variety of practice sites. Although triangulation of data collection methods can contribute to overall rigour and trustworthiness of the study, it is also more time consuming and may require a greater number of participants or more time with the same participants and is more expensive.

Discussion

Table I illustrates the decisions made by applying this scaffolding process that encouraged the researchers to consider the research objectives within the broader context of epistemology, theoretical perspective, methodology and then methods. The data collection methods used helped to glean insights into the rewards and pride that primary

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care providers feel when providing continuity of care that is built on long-term

relationships with their patients.

Table 1 Resulting Research Design.				
Research Objectives	Epistemology	Theoretical Perspectives	Methodology	Methods
1. To engage with primary care providers to better understand their desire to work in and their experiences of providing mental health care in primary care settings.	Construction-ism	Symbolic Interactionism	Constructivist grounded theory	Individual interviews
2. To engage with primary care providers and mental health care providers to gain an understanding of the primary care providers' need for IPC to deliver mental health care in primary care settings.		Group Dynamics: Norms Group Roles Group Development		Focus group interviews
3. To engage with primary and mental health care providers to examine and detail the IPC process in primary care settings considering the individual, team and system influences.				
4. To explore the opportunities and challenges of IPC in the context of the Shared Mental Health Care program with the primary and mental health care providers.				

Aligning the research objectives with congruent epistemology, theoretical perspectives and methodology helped the authors to understand selections made at each step in the research design development and influenced the selection process at the succeeding steps. Overall, adopting a scaffolding approach resulted in a more scientifically solid and rigourous proposal that has a even stronger potential to contribute meaningfully to understanding the IPC process used in the context of a Shared Mental Health Care program.

In addition to considering the theoretical perspective to select data collection methods, the authors suggest returning to the theoretical underpinnings to further explore the features of the selected data collection method (see Figure 2). For example, after the researcher gains an understanding of group dynamics and selects focus groups as one of their data collection tools, they may want to further study this literature to ponder the pragmatics of the group interview format. Experts in the field of small groups encourage facilitators to consider issues such as the number of participants per group, duration and location of the group, rules or norms that may encourage or discourage open, respectful dialogue and the number of facilitators (Yalom & Leszcz, 2005). Contemplating these practical issues in the context of group dynamics, the researcher may prepare for the focus group more informed. Thus, returning to the theory may further clarify the researcher's understanding of the inherent advantages and drawbacks of the selected data collection method.

Figure 2. Crotty's research path modified (1998 p. 4)

STEP 1: Research Objectives

STEP 2: Epistemology

STEP 3: Theoretical Perspective

STEP 4: Methodology

STEP 5: Methods

STEP 6: Theoretical Perspectives Underlying the Data Collection Method
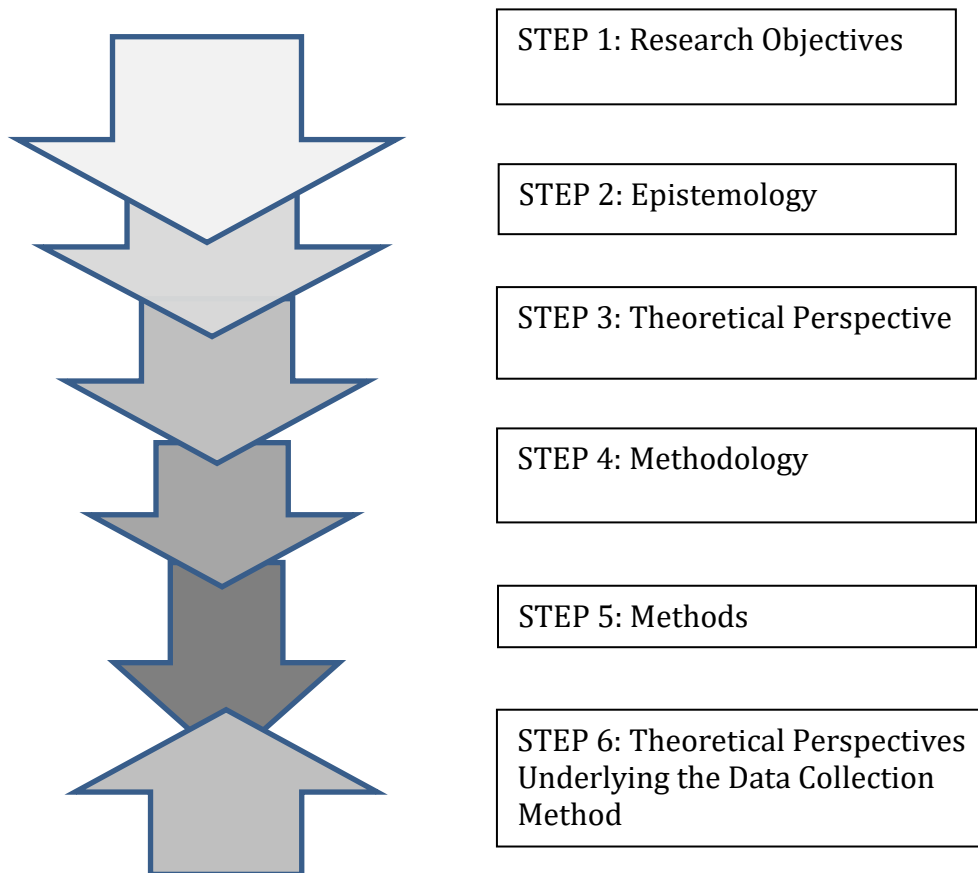
Figure 2. Crotty's research path modified (modified and republished with permission of Sage publications, from The Foundations of Social Research: Meaning and perspective in the research process, Michael Crotty, 1998; permission conveyed through Copyright Clearance Center, Inc.).

Using a systematic process to consider and understand the position of one's research questions in the broader context of epistemology and theory provided the researchers with directions for how to align research objectives with the most fitting data collection methods. Although in reality the selection process is more iterative, the staged

version presented in this paper provides clarity for the reader. Exploring the research objectives first, then considering epistemology, theoretical perspectives, methodology and finally methods illustrated how each step makes a growing contribution to the creation of a research design that can be used to attain the objectives set forth. Furthermore, grounding the research design in the broader theoretical context lays the foundation for later discussion of how the study results are situated in the theoretical realm, helping to illuminate the unique contribution of the study. The application of this process encouraged the researchers to strive to understand the underlying rationale for the selected method that led to an approach to research design that is transparent and replicable. Using a scaffolding approach to design qualitative studies may deepen our understanding of IPC processes and make an important foundational contribution to the IPC literature.

Acknowledgements

Declaration of interest

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CHAPTER 5: STUDY DESIGN

Guiding Conceptual Framework

A conceptual framework provides direction and a rationale for the research process such as which research paradigm, methodology and methods will to be used (Crotty, 1998). A choice of conceptual framework identifies the underlying assumptions the researcher is making about reality and how knowledge is created. This study was guided by the theoretical underpinnings of symbolic interactionism (SI). SI was used to understand the interprofessional collaborative process that health care professionals employ to provide mental health care in primary care settings.

SI posits that individuals act in a manner that is consistent with the meaning one ascribes to a situation, and that this occurs within a social context or interaction (Blumer, 1969). The meanings of these social interactions are then modified via ongoing interpretation of the experiences and in the context of one's life experiences (Charmaz, 2014). Interactions between individuals are based on each individual's interpretation and ascribed meaning for a given social situation. SI is, by nature, an inter-subjective process (Blumer, 1969; Prus, 1994). As interprofessional collaboration requires interaction between a minimum of two people from different health care professions, it is an inter-subjective experience. Therefore, SI provided a meaningful backdrop for this study.

SI provided theoretical guidance for this study in three ways:

1) SI asserts that meaning is a product of co-creation, developed through communication and interpretation of the interaction between people (Prus, 1994). Language and symbols are the way that individuals share their ascribed meaning and actions (Charmaz, 2014; Hewitt & Shulman, 2011). Considering that the focus of this

study is on the interactions between health care providers who use language and symbols to communicate interprofessionally, SI is critical to this study.

2) SI recognizes that the subjective meaning of any communication is grounded in a specific context. Accordingly, human behaviour cannot be understood separate from the context in which people interact (Prus, 1996). This study focused on the participants' experience and expression of the collaborative process in the context of providing mental health care to patients in a primary care setting. Thus, the meaning ascribed to the interprofessional collaborative interactions is context specific.

3) SI assumes that multiple realities exist, given that an individual conceives the interpretation and meaning to describe an event. Two people interacting may ascribe different meaning to the same event. Interprofessional collaboration requires that interacting professionals be from different health care backgrounds. Each professional enters interprofessional interactions with his or her own set of "uniprofessional" (Barr, 2005, p.xxiv) beliefs, values, and attitudes that will impact the ascribed meaning he or she attaches to any given situation. Furthermore, interprofessional collaboration is thought to be at its best when different professionals offer their unique expertise. Therefore by its very definition, interprofessional collaboration assumes that interacting professionals will have different perspectives, each of their own value. Thus, acknowledgement of multiple realities was a necessity for this study.

These three aspects of SI, namely, the belief that individuals interpret and ascribe meaning to their social situations, the role of language and symbols in expressing this individually ascribed meaning, and the existence of multiple realities, underscore the appropriateness of a qualitative paradigm for this particular study. In the context of a

shared mental health care team, each individual attributes meaning to actions and the interprofessional collaborative process would be a result of these interpreted meanings by the team members. According to Prus (1996), only a qualitative paradigm, where the focus is on understanding these interactions, enables the researcher to focus on inter-subjective experiences. Furthermore, only a qualitative approach will capture these multiple perspectives and provide the tools to interpret their meaning without reducing the data to a single truth.

Aspects of social psychology theory also provided guidance for this study. Specifically, as this study focused on the interactions amongst health care providers, gaining an understanding of inter-provider dynamics was additive. Although there is little research on interprofessional health care provider dynamics, small group theory has most often been used to illuminate the intra-provider dynamics amongst health care professionals who work together (Drinka & Clark, 2000). Theory related to group dynamics including cohesion (Yalom & Leszcz, 2005), group norms (Benne & Sheats, 1948), group roles (Feldman, 1984) and group development (Tuckman & Jensen, 1977; Tuckman & Tuckman, 1964) was considered in developing the interview guide and during the focus groups.

Study Design

A qualitative grounded theory study was used to ascertain an accurate, in-depth understanding of the CMHC team's interprofessional collaborative processes. As meaning is not fixed (Herman & Verschaeve, 2003), a grounded theory approach involving multiple data collection methods facilitated the exploration of multiple realities, that is, the realities at any given point in time as experienced by an individual.

As the student researcher was interested in understanding the emic experience of developing and maintaining collaborative relationships for the purpose of providing mental health care, being able to explore multiple realities was critical for this study to attain its purpose. Social constructionist grounded theory as described by Charmaz (2006) was used, to allow the realities of the interprofessional collaborative process to be expressed from several different perspectives, and recognizing that the data and analysis are co-created by the shared experience of research participants and researcher. Realities emerge as individuals attribute meaning to and develop a unique understanding of an experience. However these realities may be different for different individuals leading to the existence of multiple realities. Rather than focusing on confirmation, this study, congruent with constructionist grounded theory approach, focused on understanding the interprofessional collaborative process between primary care and mental health care providers. Harmonious with SI, it is through interpretation that an understanding of the subjective meaning of action will emerge (Charmaz, 2006).

Grounded theory is used when the study interest is in process (Glaser & Strauss, 1967; Strauss & Corbin, 1990) as opposed to outcome, and when the goal is discovery versus confirmation (Charmaz, 2006). Using grounded theory provided an understanding of the health care providers' expression of their interprofessional collaborative experiences, and recognized that this understanding must be studied within the social, situational and contextual realms of primary care settings.

The constant comparative method of grounded theory, where researchers collect and analyze data simultaneously, created an iterative approach allowing emerging data to direct the type of further information required as well as, a process for identifying the

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best source of future data collection. As the data was collected, the process of analysis also began. As is typical for qualitative research, this type of approach allowed for the emergence of codes and categories that informed the researcher's next steps of data collection and analysis. Comparisons were made during each stage of analysis keeping the researcher close to the data collected.

A constructionist grounded theory approach highlights the reflexive stance necessary towards data collection and data analysis. Constructionist grounded theory, as opposed to traditional grounded theory, overtly acknowledges that as data and data analysis are socially constructed, with meanings attributed by the participants and researcher. Reflexivity is critical at all stages of the research and theory development by the researchers is interpretative. Thus, the researchers assumptions are acknowledged and reflected upon to understand how they affect the research.

Methodology

A qualitative grounded theory approach was used to ascertain an accurate, in-depth and complete description of the interprofessional health care team's interprofessional collaboration process. This study used social constructionist grounded theory (Charmaz, 2006) allowing the realities of the interprofessional collaborative process to be expressed from several different perspectives. True to this approach, this study is grounded in a fundamental belief in multiple realities that are determined within a context and through the interaction and social construction shared by the participants and the meaning that each ascribes to the interactions. Distinct realities emerge as individuals attribute meaning to and develop a unique understanding of an experience, leading to the existence of multiple realities. Rather than focusing on confirmation, this

study, congruent with constructionist grounded theory approach, focused on understanding the interprofessional collaborative process used to provide mental health care in primary care settings. Harmonious with symbolic interaction it is through interpretation that an understanding of the subjective meaning of action will emerge (Charmaz, 2006).

Grounded theory was used to provide a *holistic* understanding of the interprofessional health care team's expression, including their individual and collective perspectives. This approach was used to develop an emergent model of how groups of individuals develop their intra-group relationships and how that facilitates the delivery of mental health care in primary care settings. In keeping with qualitative grounded theory, the interprofessional collaborative process was studied within the social, situational and contextual realms of a collaborative mental health care service.

Methods

Recruitment and Sampling Strategies

This study took place within a health care region in Manitoba, Canada. The participants were either health care professionals who provided mental health services or consultation in primary care settings via the CMHC program or CMHC program leaders in the health care region. Research participants included: Phase 1- primary care physicians and nurse practitioners (PCP), and Phase 2-PCP, psychiatrists, and counsellors who were co-located, and CMHC program leaders.

Phase 1 Participants and recruitment strategies: To reach objective 1 of understanding and detailing the nature and conditions under which collaboration between the PCP and mental health care providers is required, two types of participants were

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recruited for this phase of the study: 1) primary care physicians and 2) nurse practitioners working at primary care sites.

At the request of the CMHC program leaders, primary care physicians and nurse practitioners, who were recruited for but did not have the opportunity to participate in a previous study (H2009:279 and H2009:280) were invited to participate in this study (Appendix A). This recruitment strategy was not successful and therefore initial sampling included an email invitation to all 110 primary care providers (PCPs) that participated in the CMHC program (Appendix B). The email invitation was sent from the health region administrative staff. The recruitment email requested that interested PCPs to contact the student researcher by email or telephone to indicate their interest in participating in this study or to request further information about the study. Initial sampling aimed to recruit up to a total of 20 PCPs or NPs. Further recruitment aimed to include individuals with diverse experiences and opinions (Charmaz, 2014, Speziale & Carpenter, 2007) including participants from a variety of educational backgrounds: nursing and medicine; locations within the health region: core urban areas and suburban practices; and FPs remuneration models: a fee-for-service model or yearly salary. There was also an attempt to recruit both male and female participants who were varied in their age and years of practice.

PCPs who indicated an interest in participating in the study provided their work email address and received the informed consent form (Appendix C) via email. Approximately one week following the mailing of the informed consent form, the student researcher contacted the PCP to schedule an interview time and location that was convenient for the PCP. The student researcher gained signed consent at the beginning of each interview.

Phase 2 Participants and recruitment strategies: The constant comparison analysis of the initial PCP interviews provided direction for theoretical sampling to expand on the emergent categories (Charmaz, 2014; Draucker, Martsolf, Ross, & Rusk, 2007). To further understand the need for interprofessional collaboration (study objective 1), to detail the PCPs and mental health care providers' experiences and perspectives of interprofessional collaboration (study objective 2), including identifying how the individual (micro), group of multiple providers (meso), and program leaders (macro) conditions influence the interprofessional collaboration process (study objective 3), and to understand the opportunities and challenges of the interprofessional collaboration process (objective 4) in the context of CMHC, five types of participants were recruited for this study: 1) FPs, 2) NPs, 3) counsellors, 4) psychiatrists working at primary care sites, and 5) CMHC program leaders.

The student researcher presented the findings of phase 1 to the CMHC program counsellors at their monthly meeting. At the end of this presentation, recruitment flyers were provided to all CMHC Counselors to distribute at their CMHC sites to all PCPs and mental health care providers (Appendix D). In addition, PCPs who provided consent during phase 1 and who were to be contacted in the future were sent a recruitment letter via email. In the recruitment flyer, interested PCPs or mental health care providers were asked to contact the student researcher by email or telephone to indicate their interest in participating in this study or to request further information about the study. Providers who indicated an interest in participating in the study were encouraged to invite other providers at their site to participate in a focus group to discuss interprofessional

collaboration. All PCPs and mental health care providers that were participating in the regional health CMHC program were eligible to participate in this study.

Further theoretical sampling was conducted upon completion of the constant comparison analysis of both the initial PCP and the group interviews to gain further understanding of the macro level influence on the interprofessional collaborative relationship. Therefore, CMHC providers, there was also a separate recruitment of those health care professionals who formed the CMHC "Leadership Group" who were the program managers. As the student researcher met with this group to receive study approval as well as advice, recruitment followed the common communication pathway already established between the two parties. The student researcher sent a recruitment invitation (Appendix E) by email to the CMHC Program Leaders who forwarded the email to the other members of the Leadership Group. The members of the Leadership Group indicated their interest in participating in the study by responding by email to the student researcher or requested that their contact information be provided to the student researcher via the Service Manager or program administrative personnel.

Phase 2 Obtaining Informed Consent to Participate: PCPs and mental health care providers who indicated an interest in participating in this study, were asked to provide their work email address. The informed consent form was sent to all providers who indicated an interest in participating in the study (Appendix F). Approximately one week after the informed consent form was emailed, the student researcher contacted providers to schedule an interview time and location that was convenient for the group of health care providers. The student researcher gained signed consent at the beginning of each focus group interview.

For the Program Leadership focus group interview, informed consent was reviewed and gained at the beginning of the focus group interview (Appendix G).

Participants

The participants included 39 health care professionals and one system management expert. Of the health care professionals, 34 were care providers who varied in age from 30-60 years. The program leadership group included individuals with over 20 years of experience in health care. Further details are not being provided about the leadership group to protect the confidentiality of the participants.

Data Collection

To gain an in-depth understanding of the interprofessional collaborative process, data were collected from three different groups of participants sequentially, and over an extended period of time. Data collection began with the individual PCPs, followed by the health care provider groups, and finally with the program leaders. Keeping true to grounded theory, the data collection and data analysis occurred simultaneously with the emergent findings setting the direction for future data collection.

Socio-Demographic Questionnaire

Information about the individual participants and their practice was collected via questionnaire and analyzed using descriptive statistical methods. The questionnaire provided self-reported information about the participant, the practice setting and the frequency of interprofessional consultation (Appendices H-I). The questionnaires were completed by the participant prior to the interview.

Interviews

According to Charmaz (2014), qualitative researchers often rely on interviews of key informants as a main source of data collection. As suggest by Charmaz (2014), the student researcher created detailed interview guides that were used to facilitate the interviews. However, in keeping with the approach suggested by Charmaz (2014), the student remained responsive to participants' answers and open to new areas that may not have previously occurred to the researcher.

PCP Individual Interviews

Semi-structured individual interviews using an interview guide were conducted by the student researcher to gain an in-depth understanding of the PCP's need for collaboration (Appendix J). As key informants, the PCPs participating in the CMHC are positioned to provide a rich description of their experiences of the need for collaboration as well as their experiences collaborating with mental health experts. Interviews are the most often used method of qualitative data collection and are used to gain insights into perceptions or experiences of a particular phenomenon and the meaning that these experiences hold for the participants (Charmaz, 2014; Sandelowski, 2000). The student researcher used key characteristics of interviewing as outlined by Charmaz (2014) to guide the interview process:

> 1) selection of research participants who have first-hand experience that fits the
>
> research topic, 2) in-depth exploration of participants' experience and situations,
>
> 3) reliance on open-ended questions, 4) objective of obtaining detailed responses,
>
> 5) emphasis on understanding the research participant's perspective, meanings,

and experience, and 6) practice of following up on unanticipated areas of inquiry, hints, and implicit views and accounts of actions (p.56).

A total of 16 interviews were conducted lasting 45-60 minutes in length. Individual interviews permitted the researcher to explore the unique experiences of each of the 16 PCP participants. All interviews were digitally audio-recorded and transcribed verbatim. The student researcher made field notes before and after the interviews to further capture the interview context and description of the participant's non-verbal communication that could not be captured through recordings. Following each interview, the student researcher digitally audio-recorded her perceptions of the interview and emerging ideas and noted gaps.

PCP and Mental Health Care Providers Focus Group Interviews

Semi-structured group interviews were conducted with groups of key informants including FPs, NPs, counsellors and psychiatrists using an interview guide (Appendix K). The purpose of these group interviews was to collect data to address study objectives 2-4. More specifically, the interview guide included questions intended to gather information about the provider groups' perceived need for and experiences of interprofessional collaboration, to understand the multiple providers' or meso influence on the relationship building process, and to identify opportunities and challenges of interprofessional collaboration to deliver mental health care in primary care settings.

Focus group interviewing as a data collection method, allowed the participants to collectively discuss their perceptions, experiences, and meanings of interprofessional collaboration. Using focus groups allowed individuals to build from the comments of others, stimulating increased description or detail (Speziale & Carpenter, 2007). In a

focus group, members can openly share their experience, opinions and thoughts with equal respect for varying opinions. This method of data collection brings individuals together and the sharing or co-construction process is part of the experience (Leboux, Poland & Daudelin, 2006). In addition to the focus on content, observation of the focus groups provided opportunity for a deeper understanding of intra-group and interprofessional dynamics that influence collaboration (Halkier, 2010; Speziale & Carpenter, 2007).

Unique to focus groups, researchers may observe and analyze social interaction in addition to the group content (Halkier, 2010; Warr, 2005). To capture this rich data, facilitation of the focus group was conducted by the student researcher who is an experienced leader and an expert in small group process (Vicsek, 2005).

Six provider group interviews lasting approximately 90 minutes were conducted. All interviews were digitally audio-recorded and transcribed verbatim. The student researcher made field notes before and after the interviews to further capture the interview context and description of the participant's non-verbal communication that could not be captured through recordings. Following each interview the student researcher digitally audio-recorded her perceptions of the interview, emerging ideas and noted gaps.

Program Leaders Interviews

Semi-structured group and individual interviews were conducted with key informants from the Program Leadership Group. In total, eight program leaders participated in individual (3) or group (5) interviews lasting 45-90 minutes. The group leader interviews were conducted by the student researcher using an interview guide

(Appendix L). These interviews were used to gather data to understand the system or macro influences on the interprofessional collaborative relationship building process as well as perceptions of opportunities and challenges of interprofessional collaboration to deliver mental health services in primary care.

Once the interviews were transcribed, member checking occurred. Participants were emailed their interview and invited make correction of errors or omissions.

Data Analysis

Socio-Demographics

Socio-demographic information was transferred from each participant's completed questionnaire to a Microsoft Excel^{TM} spreadsheet. Data was then analyzed using descriptive statistics.

Interviews and Field Notes

All of the individual and group interviews were digitally audio-recorded and then transcribed verbatim into a Microsoft Word^{TM} format. All identifiers were removed during the transcription process and participants were assigned a study number that was used in all aspects of the data analysis. Field notes were digitally recorded by the student researcher and then transcribed verbatim. Transcribed field notes were included at the end of the transcriptions. The constant comparison approach to analysis was used throughout the study to compare new data with existing data and emerging categories (Charmaz, 2006). For this study, comparisons were done within an individual or group interview and between interviews. The student researcher noted similarities and differences between codes and emergent categories as well as relationships between categories.

In keeping with Charmaz's approach to grounded theory, transcripts were read several times to gain an understanding of the whole (2014). Once the student researcher was familiar with the interview transcript, the coding process began with initial or open coding (Charmaz, 2006). The student researcher began by first coding the data line-by-line assigning initial codes manually for each transcript and writing emergent analytic ideas on the right hand side of the transcript (Charmaz, 2006). This initial coding was intended to gain an understanding of the PCPs' experiences and ascribed meaning of needing help to provide mental health services. The student researcher continued the process of initial coding for the first seven of 16 PCP individual interviews. The student researcher then wrote memos on each participant gaining a sense of the significant aspects of each individual's interprofessional collaborative experience and the meaning of interprofessional collaboration. Charmaz (2014) suggests that early memo writing can be particularly helpful in gaining a deep understanding of the data.

After completing the initial coding and memo writing for seven PCP interviews all seven transcripts were re-read to ensure the participants' experiences and the ascribed meaning were captured by the codes and memos. Codes were then transferred to a Microsoft Word^{TM} document and placed into a table that included the code, definition, and pieces of data that exemplified the code. Memos were sorted and additional codes and explanations were added to the coding table.

This same analytic process was used for the remaining nine interviews. Initial coding and sorted memos were used to create codes that were entered into the coding table, while remaining open to new emergent codes. Once the coding table was collapsed, three preliminary categories emerged. These preliminary categories were presented in a

poster and newsletter (Appendix M). Analysis continued with further memo writing. These memos were sorted and the preliminary categories were refined and presented in a second newsletter that was distributed to all study participants and program leaders (Appendix M). The primary care provider study participants and the program leaders were encouraged to provide feedback on these preliminary categories.

The student researcher then analyzed the group of provider interviews by beginning with initial coding and noting analytic ideas on the right hand side of the transcript. Similar to the earlier analysis process, codes were grouped and used to further describe or expand upon existing codes and categories. New emergent categories were also added to the coding table.

Next, memos were written for all provider groups to further understand the participants' experiences. All memos, including individual PCPs and group providers, were re-read, sorted and then added to the coding table. Finally, the program leader group interview transcript and the individual program leaders' transcripts were coded and memos were written and sorted.

Successive memo writing is recommended as a way to ensure the continuation of the analysis process and "helps to increase the level of abstraction of the researcher's ideas" (Charmaz, 2014, p.162). In this study memos helped to analyze emergent codes across interviews and to identify those codes that were most significant.

Once data saturation was achieved the iterative process of data collection and analysis was completed, resulting in an interpretative rendering of the participants' experience of interprofessional collaboration.

Methods to Enhance Trustworthiness

This study included several methods to ensure study trustworthiness as described by Shenton (2004). In Chapter 4, the scaffolding process of how the study data collection methods and study questions were aligned is outlined. This alignment strengthened the credibility and dependability of the study. The student researcher also discussed all aspects of this study with the thesis advisor who is an expert qualitative researcher with many years of experience conducting research in the area of mental health. The student researcher spent time developing a relationship with the regional CMHC program prior to data collection. This early relationship building process allowed the researcher to become familiar with the culture of the participating organization, as recommended by Shenton (2004) to support the study credibility. As well, thick description (Charmaz, 2014) including many participants' quotes was used in the presentation of the findings. Data for this study were collected for over two years. To increase the variation in the sample, participants were recruited from different geographical locations and from practices that employed either fee-for-service or a yearly salary remuneration model. There was also an attempt made to include approximately an equal number of PCP participants from both of the remuneration models, fee-for-service and yearly salaried. An audit trail and reflexive journal were kept to establish confirmability (Shenton, 2004; Speziale & Carpenter, 2007). Preliminary themes, final overarching themes, categories and the emergent model were shared with the researcher's advisor and study participants. Transferability was explored by solicitation of feedback at national collaborative mental health and interprofessional collaborative practice conferences (Charmaz, 2006; Shenton, 2004; Speziale & Carpenter, 2007). In particular, the results were presented to health care

leaders that included managers of many health care programs beyond mental health and primary care such as, audiology and speech and language pathology, chronic care disease management, clinical health psychology, dental hygiene, nutrition, occupational therapy, physical therapy, social work, and respiratory therapy. Feedback was also solicited from occupational therapist academics and practitioners from a wide variety of clinical areas. Credibility was attained by using an iterative process of data collection and analysis and through triangulation of data collection methods that included both individual and group interviews (Shenton, 2004). These measures taken together, support the dependability, transferability, credibility, and confirmability of the study.

Ethical Considerations

Ethical approval was obtained from the University of Manitoba Health Research Ethics Board (H2011:33) and the research committee of the Winnipeg Regional Health Authority. Throughout this study attention was given to maintaining high ethical standards. Particular attention was paid to informed consent and confidentiality. All participants were provided information about the study and opportunities to ask clarifying questions prior to signing the consent form. Identifying information was removed during the transcription process and demographic data that could be identifying were aggregated so as to protect confidentiality. Interviews were reviewed by the student researcher to remove other identifying data such as places or persons. Each study participant was assigned a study number during data analysis process and then a pseudonym in each of the two manuscripts that describe the study findings (Chapters 7 & 8).

Although this study had minimal potential for harm, the focus group interviews included health care providers who work together on a daily basis. Therefore, special

attention was paid to ensure that the focus group participants were comfortable being interviewed in this format. Focus group participants were aware of who would be in their group as their peers recruited them. As well, alternative interview formats were offered.

During the interviews care was taken to offer a safe environment within which participants could share their stories. Interview rooms were selected and reserved by the participants. The initial three interview transcripts were reviewed by the thesis advisor to ensure the student researcher was providing the opportunities for participants to engage and to share their experiences.

Participants were provided with the option of participating in the study on work time or on outside of work time. Upon the recommendation of the regional health authority all participants who engaged in the study outside of work time were provided with a $100 honorarium.

CHAPTER 6: INTRODUCTION TO THE FINDINGS

The study findings are presented in two separate manuscripts. The first of these two manuscripts entitled, Collaborating in the Context of Co-Location: A Grounded Theory Study, is presented in Chapter 7. This manuscript describes the findings and emergent model of how the health care providers that participated in this study described building and sustaining their collaborative relationships to deliver mental health care in primary care settings. This first manuscript specifically addressed the four research objectives: 1) to identify the primary care providers' need for collaboration, 2) to detail the mental health care providers' and primary care providers' experiences and perspectives of interprofessional collaboration, 3) to understand the individual, groups of providers, and service leaders perspectives of the relationship building process and 4) to identify the opportunities and challenges of interprofessional collaborative relationship building all in the context of a Collaborative Mental Health Care service. Beyond addressing the study objectives individually, the manuscript described the emergent developmental model that captured how the research participants described developing their collaborative relationships over time. The first stage of the developmental model, "Looking for Help" addressed study objective 1. The second, third and fourth model stages, "Initiating Co-location, Fitting-in", and "Growing Reciprocity" respectively, addressed study objectives 2 and 3. Study objective 4, identifying the opportunities and challenges of developing interprofessional collaborative relationships in a CMHC context is described in each of the developmental stages presented.

The second manuscript entitled Looking for Help: Primary Care Providers' Need for Collaboration to Deliver Primary Mental Health Care Services is in Chapter 8. This

manuscript further addressed study objective 1 by further exploring the first stage of the

relationship building process, Looking for Help. This first stage of the interprofessional

collaborative relationship building model includes circumstances that primary care

providers' seek the expertise of mental health care providers. While primary care

providers are generalists who provide most of the required mental health care, these

research participants described being uncomfortable and ill-prepared to provide services

when the patients' needs were beyond their clinical capacity. The manuscript defined the

parameters of the primary care providers, family physicians' and nurse practitioners'

knowledge, and ability to provide mental health services with and without consultation

from mental health specialists. The results section of this manuscript underscore that

PCPs are often used to being sole providers and are autonomous health care professionals

who are open to developing collaborative relationships when they perceive that they do

not have the knowledge, skills or time to provide care.

CHAPTER 7: COLLABORATING IN THE CONTEXT OF CO-LOCATION: A GROUNDED THEORY STUDY

Abstract

Background: Most individuals with mental health concerns seek care from their primary care provider, who may lack comfort, knowledge, and time to provide care. Interprofessional collaboration between providers improves access to primary mental health services and increases primary care providers' comfort offering these services. Building and sustaining interprofessional relationships is foundational to collaborative practice in primary care settings. However, little is known about the relationship building process within these collaborative relationships. The purpose of this grounded theory study was to gain a theoretical understanding of the interprofessional collaborative relationship building process to guide health care providers and leaders as they integrate mental health services into primary care settings.

Methods: Forty primary and mental health care providers completed a demographic questionnaire and participated in either an individual or group interview. Interviews were audio-recorded and transcribed verbatim. Transcripts were reviewed several times and then individually coded. Codes were reviewed and similar codes were collapsed to form categories using constant comparison. All codes and categories were discussed amongst the researchers and the final categories and core category was agreed upon using constant comparison and consensus.

Results: A four-stage developmental interprofessional collaborative relationship-building model explained the emergent core category of Collaboration in the Context of Co-location. The four stages included 1) Looking for Help, 2) Initiating Co-location, 3) Fitting-in, and 4) Growing Reciprocity. A patient-focus and communication strategies

were essential processes throughout the interprofessional collaborative relationship building process.

Conclusions: Building interprofessional collaborative relationships amongst health care providers are essential to delivering mental health services in primary care settings. This developmental model describes the process of how these relationships are co-created and supported by the health care region. Furthermore, the model emphasizes that all providers must develop and sustain a patient-focus and communication strategies that are flexible. Applying this model, health care providers can guide the creation and sustainability of primary care interprofessional collaborative relationships. Moreover, this model may guide health care leaders and policy makers as they initiate interprofessional collaborative practice in other health care settings.

Background

Individual Canadians seeking mental health services are most often seen by their primary care provider (PCP). Watson, Heppner, Roos, Reid, and Katz (2005) reported that 30–40 % of Canadians who visit their PCP have symptoms of a mental illness. Individuals with mental illness make up at least 20% of primary care patient visits (Fleury, Imboua, Aube, Farand, & Lambert, 2012) and take up approximately 25–50% of the PCP's practice time (Macfarlane, 2005). PCPs treat more than 50% of Canadians who are seeking mental health services (Lin & Goering, 1999; Mulvale, Ableson, & Goering, 2007; Rhodes et al., 2006), while mental health specialists treat only 25% of these individuals (Health Canada, 2005; Lin & Goering, 1999). Given these statistics, PCPs make a significant contribution to the overall Canadian mental health system.

Although PCPs provide most of the mental health services, their knowledge, skills, and comfort working with those who have mental illness varies. Some authors discuss family physician's (FP) feelings of discomfort working with patients with depression (Anthony et al., 2010; Benzer et al., 2012; Fickel, Parker, Yano, & Kirchner, 2007; Henke, Chou, Chanin, Zides, & Scholle, 2008). Other authors discuss the lack of PCPs' knowledge and experience as a barrier to treating patients with depression. For example, Henke et al. (2008) describe a qualitative study using semi-structured interviews to gather information about the barriers to working with patients with depression. These authors collected data from 23 FPs who are practicing throughout the United States. In describing the study, the authors include their methods for creating the interview guide, the interview process and details of how they used a grounded theory

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approach to analyze the data. These authors reported six barriers to working with patients with depression including, difficulty diagnosing and a lack of experience. Anthony et al. (2010) conducted a mixed methods study of 40 PCPs including FPs, NPs, and general internists from one large urban centre in the United States. These authors sought to understand PCPs' decision to refer patients for depression care. The authors provide a thorough description of study process including, methodology, data collection instruments, and the specifics of the data analysis. The reported results of this study described the participants discomfort treating patients with depression. Prescribing medication is an important aspect of evidence-based treatment for depression and anxiety (Parikh et al., 2009). However, FPs report moderate levels of comfort prescribing medications for these patients (Swenson et al., 2008). For example, Craven and Bland (2006) who conducted a comprehensive literature review reported that PCPs are comfortable treating individuals with mental illness who are responsive to medication that the provider is familiar with prescribing. Goossen et al. (2012) conducted a mixed methods evaluation of an existing CMHC program reported that PCPs, are less comfortable when medications need to be changed or combined; a practice outlined in Canadian practice guidelines as an important part of improving a patient response (Lam et al., 2009).

In addition to prescribing medications, PCPs are aware of the effectiveness of evidence-based counseling. Grenier, Chomienne, Gaboury, Ritchie and Hogg, (2008) surveyed 118 FPs in one Canadian province and found that 95% of FPs knew of evidence-based counseling for depression and anxiety such as, cognitive behavioural or interpersonal therapy. These authors note that a lack of time and training make it difficult

for PCPs to implement counseling within their practices. While individuals with mental illness are most likely to be treated by a PCP, the practitioner may not possess the comfort, training or time to implement evidence-based treatment, leaving patients with less than optimal mental health services.

PCPs believe that their ability to deliver mental health services would improve if they had support from mental health specialists (Craven, Cohen, Campbell, Williams, & Kates, 1997; Kates, Fugere, & Farrar, 2004). Acknowledging that most of the mental health services in Canada are provided by PCPs, physician leaders recognized the need to increase PCPs' access to mental health specialists in primary care settings. In 1997, the Canadian Psychiatric Association and the College of Family Physicians of Canada together developed a position paper calling on PCPs and psychiatrists to work together (Kates et al., 1997). In this paper, Kates, et al. declared that primary and mental health care providers were joining together to improve access to mental health services in what is referred to as shared or collaborative mental health care (CMHC), two terms that are used synonymously in this paper (Craven & Bland, 2006). Furthermore, these two professional groups agreed that: "…family physicians and psychiatrists work more cooperatively to integrate their respective skills and expertise in a complementary and cost effective manner" (Craven & Handfield-Jones, 1997, p. 1785).

Although it was agreed that generalists, PCPs and specialists, mental health providers would work together, little was known about how to develop the collaborative relationship and the importance of relationship building to the overall interprofessional collaborative process.

Today, well over 100 CMHC programs exist in Canada, each reporting successes (Kates & Ackerman, 2002). For example, Kates (1999) discussed CMHC that were integrated into Ontario's family health teams and who saw symptom reduction and improved functionality for 50 % of the patients with mental health concerns. Bower et al. examined outcomes of CMHC for depression and concluded that partnering with case managers who receive supervision from a mental health specialist improved outcomes (Bower, Gilbody, Richards, Fletcher, & Sutton, 1999). In terms of system changes, researchers report that CMHC results in increased access to timely psychiatric care (Brown, Lent, Stirling, Takhar, & Bishop, 2002; Haggarty, Jarva, Cernovsky, Karioja, & Martin, 2012; Kates, Crustolo, Farrar, & Nikolaou, 2002; McElheran, Eaton, Rupcich, Basinger & Johnston, 2004; Sedgwick, Washburn, Newton, & Mirwaldt, 2009), decreased referrals to outpatient psychiatry clinics (Kates et al., 2002), earlier detection of mental illness, reduced utilization of specialized mental health services (van Orden, Deen, Spinhoven, Haffmans, & Hoencamp, 2015; Woltmann et al., 2012), and increased continuity of care (Goossen, Staley, & Pearson, 2008; Haggarty, Klein, Chaudhuri, Boudreau & McKinnon, 2008; Kates et al., 2002; McElheran et al., 2004). Researchers also found that individuals who participated in a CMHC program reported decreases in symptomatology, (Farrar, Kates, Crustolo & Nikolaou, 2001; Goossen et al., 2008; Haworth, Powell, Burley, & Bell, 2004; Kates, Craven, Atkinson, & el-Guebaly, 2001; Kates, Craven, Crustolo, Nikolaou, 1997; Kates, Crustolo et al., 2001; Kates, Lesser, Dawson, Devine, & Wakefield, 1987; Kates, McPherson-Doe, & George, 2011; Mulvale, Danner & Pasic, 2008) less interference with social activities (Goossen et al., 2008; Haggarty et al., 2008), and increased satisfaction (McElheran et al., 2004). Furthermore,

researchers report that implementation of CMHC increases PCPs' capacity to work with individuals with mental illness. Several researchers found that subsequent to the initiation of CMHC, PCPs reported having increased, mental health care skills and comfort (Chang et al., 2014; Farrar et al., 2001; Kates et al., 2002; McElheran et al., 2004; Kisely, Duerden, Shaddick, & Jayabarathan, 2006; Sedgwick et al., 2009) provider satisfaction (Farrar et al., 2001; Kates et al., 2002), and physician perceived patient satisfaction (Farrar et al., 2001). The World Health Organization (WHO) and the World Organizations of Family Doctors (WONCA) released *Integrating Mental Health into Primary Care* to justify the need to integrate mental health services into primary care settings. One of the key messages reported in this document is that there is less stigma and discrimination when patients with mental illness are seen in PC settings (WHO & WONCA, 2008).

While there seems to be some agreement about the value of CMHC for individuals diagnosed with common mental illness such as depression and/or anxiety, there is little consensus about the patient outcomes of CMHC with individuals with serious mental illness. Fitzpatrick et al. (2004) reported that CMHC did not improve patient outcomes for those individuals with serious mental illness. Brown et al. (2002) found FPs offered those with serious mental illness continuity of care, comfort and familiarity, and a whole person clinical approach. In a chart review, Doey et al., (2009) found that individuals with moderate to serious mental illness who participated in CMHC had reduced number of hospital and emergency room visits and patients reported high levels of satisfaction and continuity of care. Smith, Allwright, and O'Dowd (2007) explored the effectiveness of collaborative care and found that while there is some

reported improvements in patients with depression, the consistent finding was improved PCP prescribing practices.

Among those studying CMHC, there is some consensus about the components that contribute to an effective treatment program (Kates et al., 2011). For example, most CMHC programs include a case manager; psychiatric consultation; brief forms of psychotherapy or counselling such as, cognitive behavioural approaches, motivational interviewing or interpersonal approaches; patient education; access to resources; and screening for depression and anxiety (Kates et al., 2011). While these program components are essential, they must be developed upon an understanding of the PCP's need for collaboration with the mental health specialist (Goossen et al., 2012; Kates et al., 2011) and a strong collaborative interprofessional relationship (Brown et al., 2002; Paquette-Warren, Vingilis, Greenslade, & Newnam, 2006; Way, Jones, Baskerville, & Busing, 2001; Younes et al., 2005).

Historically, PCPs and mental health providers report they have poor interprofessional relationships and a lack of mutual trust and respect (Craven & Bland, 2002) that seems to underpin a proclivity toward poor communication (Craven et al., 1997). Kates stated that in addition to not meeting the needs of patients' with mental illness, the relationship between PCPs and psychiatrists was poor including, insufficient access, poor communication, and a lack of understanding and support for the role of PCPs in delivering mental health services (Kates et al., 1997). However after over a decade of CMHC, the Joint Working Group on Shared Care reported on the strides made in offering increased access to mental health services (Kates et al., 2011). More recently, Goossen et al. (2012) and Benzer et al. (2012) recognized and reported that the

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interprofessional relationship is integral to shared care between primary care generalists and mental health care specialists. Although CMHC has been in place since the late 1990s, the development and sustainment of the interprofessional collaborative relationship aspect of the shared care model, has not been well developed. Thus while the shared care model has been widely implemented, we have little knowledge about how generalist and specialists build and maintain their interprofessional collaborative relationship. An increased understanding of how to build and maintain interprofessional collaborative relationships will provide much needed guidance to those health care providers attempting to navigate this complex process.

To date, there is little understanding of the relationship building process providers use to support the ongoing engagement to work together to provide primary mental health services. Understanding the providers' perspective is essential to developing best practices that will ensure patients with mental illness receive the full benefits of the interprofessional primary mental health care team. Accordingly, we used a qualitative approach to explore the following study question: How do primary care providers and mental heath care providers collaborate to provide mental health care in primary care settings. More specifically the research objectives included:

1. To detail the need for IPC in the delivery of mental health services in primary care from the perspective of the primary healthcare providers.
2. To detail primary healthcare providers and mental healthcare providers experiences and perspectives of IPC in the context of a primary care program, Collaborative Mental Health Care program.
3. To identify how the individual, group dynamics and system influence the IPC process in the context of the Shared Mental Health Care program.

4. To identify the opportunities and challenges of IPC in the context of the Shared Mental Health Care program.

This paper describes the grounded theory of interprofessional collaborative relationship building that providers described developing and maintaining to deliver mental health services in PC settings.

Methods

Study design

This study was best approached from a qualitative research paradigm where the exploration is grounded in the providers' experiences of IPC (Creswell, 2007). The purpose of the study was not to deduce a single truth, but rather to understand the multiple realities of the participating health care providers from an emic perspective (Crotty, 1998). More specifically, social constructivist grounded theory methodology (Charmaz, 2014) was used to facilitate an inductive exploration of the interprofessional collaborative relationship building process providers use to work together to deliver mental health services in primary care. Grounded theory as described by Charmaz is an appropriate methodology to use when the study purpose is to understand, rather than try to explain process. Social constructivist grounded theory acknowledges the co-creation of the study findings by both the researchers and participants (Charmaz, 2014).

Symbolic Interaction (SI) served as the guiding theoretical framework for this study. As SI focuses on the meaning individuals ascribe to an interaction, this framework helps us to explore multiple realities rather than to seek a single explanation (Prus, 1994). In this study, using an SI lens, we focused on understanding the meaning provider participants ascribed to the interprofessional collaborative relationship building process

as they engaged to provide mental health services in primary care settings. As SI focuses

on meaning ascribed by individuals as they interact with other it is thought to be a useful

framework when one is exploring process and change (Charmaz, 2014). Further

description of the study design and conceptual framework used is available in the

methodology paper by Wener and Woodgate (2013).

Ethics, consent, and permission

The University of Manitoba Health Research Ethics Board provided ethical

approval for this study (H2011:003). Informed consent was obtained from participants

prior to the commencement of all interviews.

Consent to publish

Consent to publish anonymized individual participant's data was obtained as part

of the informed consent process.

Participants

Purposive sampling was used to recruit providers who participate in one health

region's CMHC service. All 110 PCPs, (100 FPs and ten nurse practitioners (NPs), 16

shared care counsellors, and eight shared care psychiatrists who participate in the health

region CMHC program were invited to participate through recruitment flyers. We sought

to achieve diversity in terms of geographical location of practice, physician remuneration

model, and practitioner's gender in the sample through maximum variation sampling

(Creswell, 2005). There are 11 identified communities within the urban centre, seven of

which have a CMHC service. Recruitment occurred from all seven communities that

offered CMHC. In general, family physicians within this urban centre are remunerated

using a fee-for-service model or receive a yearly salary. We sought to ensure that we

recruited a relatively equal number of family physicians from each of the remuneration

models. Previous studies have shown that the average socioeconomic status, education

and health care needs vary among these communities (MCHP). We assumed that the

patients living in each of these communities are most apt to attend health care practices

located within their communities and that these differences in income, education and

health care needs, may contribute to the health providers' interprofessional collaboration

experience. Literature suggests that females are more apt to collaborate than males,

therefore we attempted to ensure that we had representation of both male and female FPs,

NPs, psychiatrists and counsellors (Fewster-Thuente, & Velsor-Friedrich, 2008;

Williams, Domnick, & Vayda, 1998). Sampling continued until categories could account

for new data and "theoretical sufficiency" was achieved (Dey, 1997, p. 117).

Data collection

Demographic information was collected to obtain a profile of the participants.

Information about how the providers collaborate to provide mental health services in

primary care was gathered using semi-structured in-depth individual interviews and focus

groups that took place in a private room in the participant's place of work. Data was

collected from three groups of participants: 1) PCPs, 2) groups of providers that included

FPs, NPs, psychiatrists, and counsellors, and 3) health authority regional leaders. First,

PCPs were interviewed individually. The initial interview guide was created based on the

results of a literature review and a previously completed program evaluation (Goossen et

al., 2012). The interview guide for the individual PCP interviews included open-ended

questions about the patient population served, experiences providing mental health

services, need for collaboration with mental health specialist and their experiences of collaboration.

Second, interprofessional focus group interviews including PCPs, and mental health care providers were conducted. The focus group interview guide was based on the data analysis of the PCP interviews and the literature, and focused on understanding the details of the providers' experiences of interprofessional collaboration to provide mental health services to patients. Focus group interview questions were created based on the emergent themes from the PCP individual interviews and the literature, and included asking providers about the meaning of interprofessional collaboration, process of collaborating, strengths and challenges of interprofessional collaboration, process of resolving conflicts among team members, influence of co-location on the interprofessional collaboration process, and the role of the health region in interprofessional collaboration. Questions about interprofessional conflict were added to the interview guide when it was noticed that participants did not discuss this issue, although it is reported in the literature. Third, interviews with the regional leaders were conducted. The Regional leaders' and decision-makers' interview guide was created based on the emergent findings from the previous interviews. Although these interview guides were used for all interviews, the interviewer (PW) was responsive to participants' inviting them to further discuss issues raised. As well, the interviewer encouraged the participants to raise any issues that the participants wanted to discuss prior to ending each interview. A sample of interview questions from all three guides is included in Table 1.

Table 1. Sample Interview Questions

PCP Individual Interview Sample Questions
1. Tell me about your primary care practice?
2. Describe the patient population in your primary care practice?
3. Tell me about your experiences in your practice of providing health services to patients with mental health problems?
4. Tell me about an experience where you were asked by a patient to provide mental health services/support to a patient when you felt comfortable or equipped to do so?
5. Tell me about an experience where you were asked to provide mental health services/support to a patient when you did not feel comfortable or equipped to do so?
6. What have been your experiences working with the psychiatrist?
7. What have been your experiences working with the counsellor?
8. What kinds of decisions were made during these collaborations?
9. How did the collaborative decisions meet your needs?
10. How did the collaborative decisions meet your patient's needs?
PCPs and MHPs Focus Group with Sample Questions
1. Tell me what Interprofessional collaboration means to you?
2. In your particular practice tell me who is involved in the interprofessional collaboration process to deliver mental health service?
3. How does co-location influence the interprofessional collaboration process?
4. Tell me about your approach to patients?
5. How is information such as decisions communicated between health care providers?
6. What are your team's strengths?
7. What have been your biggest challenges collaborating to deliver mental health services?
8. Tell me what happens when there is disagreement between providers? How are conflicts resolved?
9. How does the Shared Care program or the regional health authority support interprofessional collaboration to deliver mental health services?

Regional Leaders and Decision-makers Focus Group and Individual Interviews Sample Questions:
1. From your perspective, what is the role of the various team members in delivering mental health care?
2. What do you see as your role in relation to delivery mental health care in primary care settings?
3. Shared care is thought to involve interprofessional collaboration, what does that mean to you?
4. Describe how interprofessional collaboration is used to deliver mental health services in primary care?
5. What structures does the program or the region provide that supports interprofessional collaboration in Shared Care Mental Health? Are there other structures that you think would provide additional support or facilitate greater collaboration?
6. What processes do you think are facilitative of interprofessional collaboration and how does the program or region support these processes? Are there other processes that you think could make a facilitating contribution to interprofessional collaboration?
7. Describe any or how the program or region impede interprofessional collaboration? What kinds of things could be changed to remove these barriers?
8. What role does this group play in developing and facilitating interprofessional collaboration?
9. What resources does this group access to encourage and support interprofessional collaboration? What kinds of resources are missing/unavailable that could further support interprofessional collaboration?

Data analysis

All demographic questionnaires were analyzed using descriptive statistics.

Individual and group interviews were audio recorded and transcribed verbatim. Prior to

initiating coding, the transcripts were read several times to gain an understanding of the

whole. In keeping with grounded theory, the coding process consisted of initial and

focused coding phases (Charmaz, 2014). We analyzed the data, assigning initial codes for

each transcript and writing memos to form initial definitions (Charmaz, 2014). Using

focused codes as preliminary categories, we wrote more in-depth memos from the first

seven interviews and used constant comparison, remaining open to new and emerging categories as we analyzed the remaining interviews (Charmaz, 2006). Authors met to discuss the overarching theme and categories to achieve consensus. Interview transcripts and a newsletter describing the preliminary findings were mailed to all study participants for feedback prior to the finalization of the overarching theme, categories and developmental model however, no participants suggested changes to the proposed categories.

We included several methods to ensure study rigour (Shenton, 2004). The credibility and dependability of this study was established by aligning data collection methods with the study questions (Wener & Woodgate, 2013). Data was collected over a long period of time and included participants from different geographical locations and from practices with different remuneration models. We kept an audit trail and reflexive journal to establish confirmability (Shenton, 2004). Transferability was explored by sharing the overarching theme, categories and developmental model with study participants and solicitation of feedback at conferences, presentations, and from peers (Charmaz, 2006; Shenton, 2004; Speziale & Carpenter, 2007).

Results

Description of participants

Health care providers ($n = 32$) and health region leaders ($n = 8$) participated in this study and completed the demographic questionnaire. Of the health care providers that participated in the study, there were 16 (50 %) FPs, 8 (25 %) nurse practitioners (NP), 3 (9.4 %) psychiatrists, and 5 (15.6 %) counsellors. Of the 16 FPs, 10 (62.5 %) reported that they participate in the provincial fee-for-service (FFS) remuneration program and 6

(37.5 %) of the FPs stated they receive a salary from the region (SFP). All NPs, psychiatrists and counsellors receive a yearly salary from the health authority, the regional body responsible for health care delivery.

The providers' ages varied within each of the provider groups from 30 years to over 60 years of age. However, within the PCP sample, FFS FPs tended to be older than either the SFPs or the NPs and the NPs tended to be older than the SFPs. For example, 70 % of FFS FPs reported they were 50 years of age or older while none of the SFPs or NPs were over 50 years of age. In terms of years with the CMHC program only one of the 32 health care provider participants had been with the CMHC program for less than one year, while ten participants had greater than 5 years' experience in the program. Taken together the health care providers worked in 12 different primary care clinics that varied in geographical location within the health region. Eleven FPs and five NPs participated in the initial individual interviews that took place over a one year period, March 2011 to February 2012. The six focus groups included two-four participants and took place over a six month from the end of November 2012 to May 2013. One counsellor, and two psychiatrists participated in more than one focus group interview because they provide service to more than one clinic. In these cases providers were directed to talk about their experiences in each clinic within the separate focus groups. One family physician participated in both an initial interview as well as a focus group and no specific directions were provided by the interviewer.

In addition to these health care providers, eight members of the regional leadership group participated in either a focus group or an individual interview based on the individual's ability to attend the focus group. These interviews took place over a two-

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month period from July 2013 to August 2013. The regional health leaders included

individuals who belonged to a variety of health professions and had additional education

in, health systems and administration. The members of this group were responsible for

overall implementation and monitoring of the CMHC program. Pseudonyms are used in

this manuscript to maintain confidentiality of study participants.

The findings revealed one overarching emergent theme, Collaborating in the

Context of Co-location that includes a four-stage developmental interprofessional

relationship building model. The emergent categories were the four stages of the

developmental model and included: Looking for Help, Initiating Co-location, Fitting-in,

and 4) Growing Reciprocity. This model and four developmental stages describe the role

of the health region leaders and the providers in creating interprofessional relationships

amongst the PCPs and mental health care providers. These relationships enabled

providers to deliver primary mental health care. The authors used member checking to

confirm that the developmental model and stages were an accurate representation of the

participants' interprofessional collaborative experiences. These developmental stages

held true across professions and gender.

Collaborating in the context of co-location was the overarching theme that

describes the evolving interprofessional relationships between primary care and mental

health care providers for the purpose of meeting primary care patients' mental health

needs. Collaborating in the context of co-location is how the mental health care providers

who are part of the CMHC program are situated within the PCPs office to facilitate the

PCP's patient-focused provision of primary mental health services. Lisa, a nurse

practitioner describes how she and a co-located psychiatrist were able to provide mental

health care when otherwise, this patient would not have received treatment. Furthermore, the psychiatrist is able to fulfill the NP's patient care need, being available at the patient's PC appointment time:

> I can think of at least, well more than one time… I had someone that was clearly very ill, with no insight. And would not agree to come and see a psychiatrist. I needed that assessment done… I just had to arrange for him to have an appointment with me… and then have our psychiatrist just kind of join us… being co-located allowed for that to happen. (NP, Lisa)

In supporting PCPs, all providers use a variety of communication methods with the explicit intention of learning to work together to both provide and enhance the capacity of primary mental health services. The providers' evolving relationship proceeds through four stages over time that begin with looking for help to provide mental health services, to a stage where providers participate as partners of patient care as shown in Figure 1. During each stage of development the providers build upon the aspects of the relationship established during the previous stage. The groups of providers were always focused on patient care using varied communication strategies that were implemented flexibly depending on the needs of the individual practice. Overall, co-located groups of providers moved through the stages at different rates of time and not all interprofessional collaborations develop to the stage of growing reciprocity.
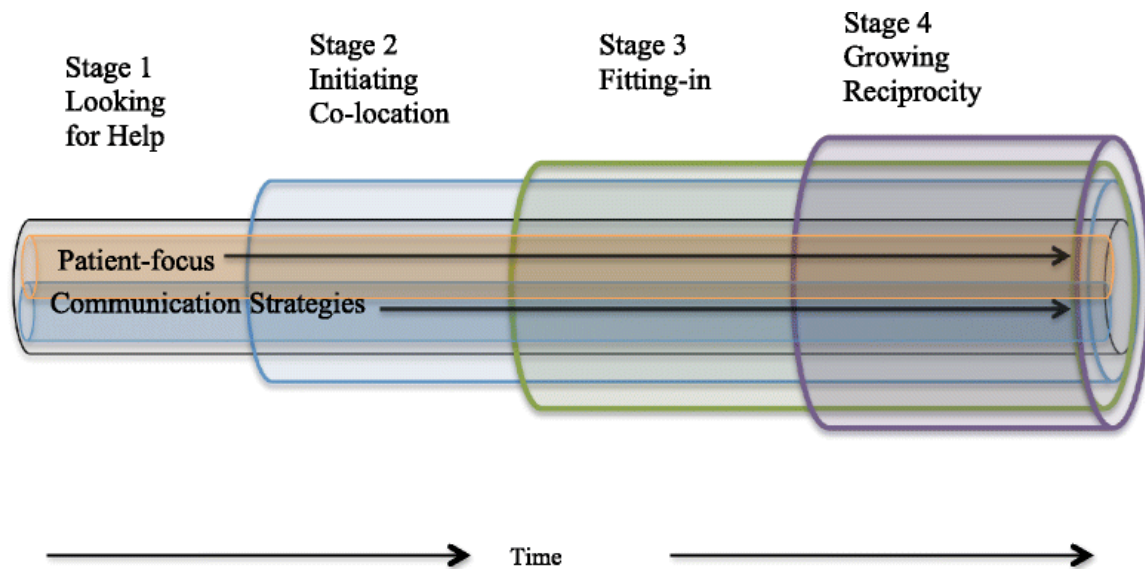
Fig. 1 Stages of Interprofessional Collaborative Relationship Building

Stage 1: Looking for help

Looking for help is when the PCPs and regional leaders look to mental health experts to work with PCPs to help PCPs to deliver mental health services in their primary care settings. Participants in this study expressed their need for help; access to mental health services and clinical experts to help them increase their mental health knowledge and skills. PCPs in this study, discuss how they need timely access to mental health services and how this access was not available prior to participating in CMHC program.

> I have worked at other places where a 3-month wait for psychiatry and an eight-week wait for counselling is a short wait. Usually by that time, the problem that the person has come in to ask for help has now fizzled in one way or the other. So you've missed that opportunity. So access in a timely manner is massive. And I think that that only expedites the patient's ability to improve or get better. (NP, Evelyn)

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Although PCPs are patient-focused and want to provide mental health services to primary care patients, they perceive they have a lack of time, comfort and/or expertise. Comfort working with patients with mild to moderate mental illness varied amongst the PCPs participating in this study, with more experienced PCPs reporting that their comfort working with patients with a mental illness has grown over time and with life experiences. Sarah expressed this growing comfort:

> I think as a whole with being in practice for a long time…I think part of it is just my own experience and my own competence or comfort with feeling not as overwhelmed with some of the people that come in with those problems. (FP, Sarah)

Participants in this study all reported that patients with mental illness that are difficult to diagnose, or that have a personality disorder, and those that are not responsive to medications require that PCPs have specialized knowledge and skills that are beyond their own clinical capacity. For example, this FP with many years in clinical practice describes the circumstances when he requires specialist help. "…mild to moderate depression I can usually handle. People with severe depression, people who present with mild to moderate depression who are not responding well to my initial approach, that's where the call for help usually comes in" (FP, Gary). As patient-focused PCPs, these study participants want to provide primary mental health services, are aware of their knowledge and skill limitations, and require help from mental health specialists.

At a health region administrative and clinical level, the leaders identified and embraced the need to enhance mental health services in primary care settings through interprofessional collaboration between generalist PCPs, and specialists mental health

care providers. As another regional health leader explained, the mental health service enhancement in primary care was logical as PCPs were already playing a key role in the mental health system, "…the need for collaboration… primary care physicians are providing a significant amount of mental health services. That's a driver". (Regional Leader, Ralf)

Stage 2: Initiating Co-location

Initiating Co-location is the regional leaders' belief in the usefulness of the CMHC model and then situating the mental health providers into the primary care clinics. As this regional leader explains, learning about collaborative mental health programs from an expert convinced her that co-location of providers was the next step in improving the mental health system: "I had been to a conference with Nick Kates (Canadian Founder of Collaborative Care) and gone to a couple of presentations and thought, this (co-locating providers) is where we need to go as a system" (Regional Leader, Leanne).

Initiating co-location, that is, geographically bringing providers together signaled to the PCPs and mental health care providers that the regional leadership was committed to intra- and interprofessional collaboration in primary care sites. A key aspect of this commitment included the health region leaders negotiating and implementing financial compensation for the use of the FFS' space, as well as providing salaries for the psychiatrists and mental health counselors. Furthermore, this financial compensation was implemented with an understanding that the providers' days would include time for interprofessional collaboration. As this counsellor and psychiatrist describe, creating the structures and processes to co-locate providers meant the regional leaders believed in the program: "the (health) region supports collaboration because they've put this structure

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into place for us" (Counsellor, Nofar); "they (the health region) pay me a salary that I'm able to participate in the program". (Psychiatrist, Eleni) Another counsellor and psychiatrist explain how initiating co-location, the regional leaders understand that providers need face-to-face time and value it as a critical component of the program. In this example the providers use the term collaboration to mean face-to-face time working together.

> …if I'm spending (face-to-face) time collaborating with any of the primary care providers, I know that Shared Care sees that as a legitimate use of my time. …from a Shared Care perspective, we still need to see a certain amount of people but the (face-to-face) time spent collaborating is equally or more important even than that as a program. (Counsellor, Elia)

> It's (collaboration) valued. (Psychiatrist, Daniel)

Unlike the PCPs on salary, initiating shared care in FFS PC sites regional leadership needed to be more flexible in how and when providers were co-located. For example, regional leaders had to negotiate with providers about the use of rooms and time for collaboration. This FP describes how part of bringing the providers together meant that providers needed to be willing to provide space for the mental health providers. While this may initially be perceived as negative, financial compensation alleviated the situation:

> …it might actually work even a little negatively because Patty (counsellor) is using one of my rooms and if I have a resident then I'm short one room, but

Shared Care does pay us sort of a token rent so in the long run there's no negative (FP, Hart)

Stage 3: Fitting-in

Fitting-in is when co-located mental health providers and PCPs begin to interact within one another to provide mental health services to PC patients'. For many PCPs, bringing providers together was about creating a familiarity with the specialist provider that was profoundly different from the historical non-co-located generalist/specialist relationship. This historical relationship was based on a consultative model rather than an interprofessional practice approach. In this relationship, the mental health care providers work to fit-in into the PC clinics, interacting with the PCPs as they provide mental health services that the PCP identifies needing for the patients. During this stage all PCP study participants identify needing mental health consultation for diagnosis, medication management, and therapy. Essential to this developmental stage is the mental health care provider being flexible with their time in order to fit in with the unique schedule of a PC clinic and/or the PCP. For example, one counsellor purposely altered his schedule to stay late into the early evening, ensuring that he was free to meet with the physicians when they were available. One of the psychiatrists at another PC setting describes waiting outside of physician's examining room to be able to "catch the doc between appointments" (Psychiatrist, David). Another FP describes how the psychiatrist and counsellor have, "learned to fit with him, Because I don't eat lunch downstairs. So, in my office, they've learned that, So if they want to find me they can." (FP, Michael)

During this stage, mental health care providers needed to develop patient-focused communication strategies that were flexible and fit with each PCP. However, in some

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practices psychiatrists and counsellors reported that not all PCPs within the practice consulted with the mental health experts. As well, some PCPs who did consult with the mental health experts did not meet face-to-face to discuss patients seen. All of the study participants, mental health providers and PCPs described how fitting-in was difficult with when providers do not meet face-to-face and how in these situations mental health services were not provided and the relationships did not progress. This counsellor describes how she is able to develop a relationship with those PCPs willing to meet with her and the challenge when PCPs are not prepared to make the time to share in the care of patients:

> The challenges, that I believe that we get along really well but I can't say that for every physician…And people do have different willingness to meet and to share and collaborate…. it's like getting the mail delivered. They love having it come to the door and they don't want it. But they don't want to necessarily go to the corner to pick it up, you know. And so we're here. Are they willing to put in extra effort? To work with me I would say, yea, it's kind of a working collaboration. Not just the talking. (Counsellor, Lori)

For this FP it is clear to him that when a PCP is not willing to meet with the mental health care provider then the PCP is declaring that they are opting out of the collaborative relationship.

> …if you're providing a service for us and be willing to talk to us and everything else, to just say I won't ever sit down with you and talk….fine, then you've excluded yourself from this group…. It's just got to be that way at some point. (FP, Michael)

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Using patient focused communication strategies such as short hallway conversations or patient referral forms along with the mental health care providers' timely service provision, providers become more familiar with one another and their interprofessional relationships develop. One of the FPs describes how the face-to-face patient focused interaction between providers is a key aspect of creating familiarity: we've said over and over again that's been a huge part …you literally can talk to somebody in the hallway … just that physical presence is helpful … a huge part for us (FP, Adi). Collaboration was difficult for PCPs who did not fit in with providers at particular clinics. For example, when the mental health care providers work on days when a PCP was not present, the PCPs did not perceive that the mental health specialist service was available:

> … maybe that is there (the ability to email or call the psychiatrist) and I'm just not aware of it. …I'm not in every day, she's in on a day that I'm not here, …I don't ever see her…. (FP, Jacquie)

Most of the mental health providers discussed how they expected PCPs to discuss their referral to the psychiatrist or counsellor with the patient to ensure there was an understanding and agreement from the patient. This counsellor suggests that PCPs who do not accept their responsibility do not fit with the CMHC program.

> I have someone (PCP) who habitually sends me people that don't show up. That this person (PCP) kind of doesn't get it or they don't communicate to their patient what it's really all about and why they have to come or why they would benefit by coming. I wouldn't want anybody seeing me because they have to. Because as

you're, some people (PCPs) just won't fit, you know. Because they have, there's

some responsibility to do something. (Counsellor, Lori)

However, as Juliette describes during this third stage when providers fit in with the PC clinic, collaboration within the context of co-location moves beyond physical proximity of providers to the receptivity providers feel amongst them: "… the biggest difference is one of familiarity cause I see Samantha (the counselor) every day that I work here and Gretta (the psychiatrist) …she's very approachable, she's happy to talk about cases." (NP, Juliette) As the providers work together to ensure the patients' mental health needs are met, they are simultaneously creating interprofessional communication and service delivery strategies that work for their particular PC practice.

Written communication is an important aspect throughout the fitting-in stage. PCPs initiate a consultation to a mental health care provider and receive written consultation reports. While mental health services are provided to the patients, mental health care providers write progress notes in a common patient chart or electronic medical records (EMR). These written forms of communication contribute to building PCPs' mental health knowledge, skills and comfort. FP participants describe how the specifics of the written communication processes are important to the PCP's capacity to treat patients. This FP describes that because the written consultation includes treatment specifics, it is facilitative of the provider's ability to comfortably treat the patient: "I would look to that written consult… they're very specific as far as recommendations go for medications, for doses, for resources." (FP, Leslie)

In contrast, one FP describes the inconsistent communication she typically experienced prior to participating in the CMHC program:

I had a patient who has a mood disorder who was admitted… I worry about these

people when I don't see them, a discharge summary may come four months after

they've been discharged from hospital, the flow of communication is often

lacking. (FP, Adi)

Although the written forms of communication are important, once the mental

health consultation process was initiated, the PCPs relied on talking directly to the mental

health providers for day-to-day patient-focused service provision. As this nurse

practitioner describes, talking with the mental health provider facilitates timely treatment

planning that is perceived to be meeting the patient's needs. "…she was evaluated and

then we had a conversation right at my desk, right after she was evaluated and we talked

about what do". (NP, Donna)

All participants discussed that during this fitting-in stage, being familiar with one

another facilitated direct communication, such as quick talks before a patient is seen or

after a patient leaves the visit. Most study participants describe using direct

communication between the PCP and counsellor as an efficient and timely approach to

patient care.

Stage 4: Growing reciprocity

This last stage in the developing interprofessional collaborative relationships in

the context of collaboration is when the providers come to know and care about one

another, value each other's personal and professional expertise, and discover shared

patient care values. The PCPs in this study appreciated when the psychiatrist and shared

care counsellor shared their knowledge and suggested assessment and treatment

approaches that enabled the PCP to respond to patients mental health needs confidently

and in a timely manner. PCPs who participated in this study expressed an unequivocal trust in the psychiatrist and shared care counsellor. For example, Jacquie a FP, expresses appreciation for and confidence in the medication management suggestions provided by the psychiatrists: "…if I'm having trouble getting the right medication, then I'll refer to the psychiatrist and then I definitely take their opinion…" (FP, Jacquie). Many study participants shared that they implemented the treatment recommendations as suggested and that they would not consider changing what was recommended: "…I would never alter it from what the psychiatrist has suggested but initially make sure I follow that exactly as they've suggested…" (NP, Susan). On the other hand, this FP defines the interprofessional relationship in terms of being most responsible and acting on behalf of the patient:

> I'm still quarterback, I'm still the guy that's running the show for my patient and I'm ultimately responsible for what's going to happen, and I have to take the advice of the consultant and decide whether I think this is appropriate or not…Sometimes knowing your patient or knowing a different circumstance saying this isn't going to work you may not follow that bit. (FP, Ira)

Participants also express relief and appreciation that the shared care counsellor knew of other mental health resources that the patients could access:

> "…knowing what other places offer counselling cause that's one of the big black holes out …I have a sense of a few things just that I've learned over time, but she (counsellor) knows a whole lot more than I do so. (FP, Adi). The PCPs relief is coupled with the counsellors' recognition of how their ability to provide assistance deepens the developing interprofessional relationship: "…once

somebody sees you actually can be helpful that will go a long way in building a

relationship." (Counsellor, Brandon)

During this stage, the interprofessional collaborative relationship becomes deeper,

as the valuing of one another's process becomes reciprocal and providers recognize that

they have shared values such as providing holistic patient care. This FP describes the

psychiatrist or counsellor looking to him to ensure the specialist has a complete and

holistic understanding of the patient "…they'll call me in and ask if any other thoughts

that I have [sic], cause a lot of these people I've known them for 35 years, I have the

advantage of experience with them". (FP, Hart) Similarly, the mental health providers

value and understand how the PCP's long-time knowledge of the patient was an

important aspect of patient care:

> There's a lot of brainstorming too because if I just meet a client, for the first time,
>
> I'll come back, (to the PCP) …these guys know that client well. And so I'll say,
>
> well this is my impression or this is kind of my feeling, what do you think? And
>
> so then it's usually we tease out kind of where we go together, you know.
>
> (Psychiatrist, Eleni)

At this stage there is an ease and comfort between providers that has moved

beyond a one-way valuing to a more comfortable reciprocal relationship that is based on

a shared value of providing patients with the best care possible. As this provider

describes there is an increasing comfort that includes flexibility "…sometimes I will go

there or they will go here or we'll meet in the corridor and say I'd like to talk about so

and so and it's a very comfortable relationship". (FP, Gary) For some groups of

providers, a perceived non-hierarchical structure was an important contributor to the

growing reciprocity. This counsellor describes the impact of perceived non-hierarchy on the providers' sense of cohesiveness

> there's respect for the different roles that people play within the clinic…that has separated this clinic in terms of functioning and cohesiveness in a way that lots of clinics set up similarly haven't really been able to achieve. And I think that it's really been because of taking out that hierarchical structure. That has made the clinic function so much better as a workplace. (Counsellor, Corey)

During this stage providers' shared value of being patient focused is heightened and together they create relationships that ensure patients have timely access to mental health services, while at the same time, retaining the PCPs' position as the key health care providers. This FP shares how the PCP and mental health specialist expressed their joint commitment to timely patient focused care:

> I know myself and at least one of my other colleagues may call him up and saying you know I've got this person or what do you think about this medication for this person that you already know and being able to make a lot of those decisions with his you know okay or with his input on a more informal and timely basis. (FP, Adi)

PCPs describe developing relationships with mental health providers that are based on trust and respect, and how this creates not only trust between providers but also trust between PCPs and the patients. This provider describes how the patients benefits from the established relationship among providers:

> … from the patient's perspective that's helpful that we actually know each other. I've said to people there's other specialists …I don't know them but I think

they're good… I think from the point of the view of the patient because it's very personal that everybody's kind of connected. (FP, Sarah)

Many of the study participants described that the collaborative relationship developed over time. This PCP shared the sense of ease and trusting collaborative relationship that develops over time:

It's also about establishing a relationship with them as well…I think the more you collaborate, the more you understand each other and the more your thinking tends to line up around how you deal with your patients or your clients. Like working with [counsellor's name] for 8 years, I know how [counsellor's name] thinks. I know what her patients are like. I know how she is going to treat her patients. I've worked with [psychiatrist's name] for, I don't know. (FP, Jacquie)

Another FP describes how the collaboration facilitates patients receiving the right care at the right time:

…if the counsellor, was to see somebody and thought this person needs medication, they would come out and talk to me about it or as I say if it's somebody that I think really needs to be seen more quickly than average I will make a point of going around and talking to the counsellor… (FP, Gary)

At this later stage of development the health care providers anticipate that as they come together to provide patient care, there will be different opinions about how best to meet the patient's needs. Providers in this study understood that these differences emanate from the providers having different knowledge and skills but that all providers are motivated to do the best for the patient. Understanding that all providers share a

common interest in meeting the needs of the patient seems to help the providers reframe interprofessional provider into a culture that welcomes diverse perspectives:

The only times there has been somewhat of a difference has been more on the impressions that we've had of what's going on because we come to it from two different angles. But I don't think there's ever been really a disagreement about how to go forward from there because it does always involve the patient and their opinion…, and their preferences. And it does also always come from a place of wanting to do the best that we can by that person. And so it's hard to imagine conflict when you have the same ultimate goal in mind. (Counsellor, Corey)

Providers express the evolving collaborative relationship with mental health providers as caring about one another on a more personal basis. This FP explains how when providers work together and get to know one another on a more personal basis, the relationship deepens and creates a closeness between providers that enriches the work relationship:

…when you know somebody and you know that they're due with their next pregnancy or who their husband is and you know what their kids do.. It's really hard to have a bad relationship when you know people really well. And it's so much easier to have great working relationships when you are that intimate with people… (FP, Taryn)

Discussion

Our study describes the stages of developing interprofessional collaborative relationships in a CMHC program in a primary care setting which to date, has received limited study. Using an SI lens allowed us to understand the meaning that the interactions

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between the regional leaders, PCPs, mental health care providers and the primary care context contributed to provider perceived interprofessional collaborative relationships. The results of our study situate co-location as a crucial component to developing interprofessional collaborative relationships in the shared care, primary care practice setting. Co-location has consistently been identified as an important factor in building collaborative teams between those in mental health and primary care (Craven & Bland, 2006; Knowles et al., 2013; Mulvale et al., 2008). Allport (1954) found that interpersonal contact is an effective way to overcome intergroup conflict, a suggestion he put forward as the *contact hypothesis*. In this study, co-locating providers set the stage to develop interprofessional collaborative relationships. Similarly, Kates et al. (2002) reported that co-location enhances communication and eases the referral process, case discussions and improves continuity of care. Participants in this study described that co-locating providers encourages interprofessional interaction that they perceive to be critical to the developing interprofessional relationships.

Hewstone and Brown (1986) agreed that interpersonal contact is important, however, they state that it is not sufficient to increase trust among group members. These authors suggest that to increase trust among group members there also needs to be personal interaction, equal status, common goals, support from the institution or agency, and cooperation. Mulvale et al. (2008) found that personal contact and face-to-face case conferences between providers is an important contributor to the success of the CMHC program and FPs who worked with co-located counsellors and psychiatrists reported the highest levels of satisfaction (Kates et al., 2004). The participants in our study also emphasized the importance of both face-to-face interaction as well as written forms of

communication. Providers in this study also discussed the importance of a non-hierarchical structure, a common focus on improving patients' mental health, and support from the program and health region leadership.

In this study, participants from different practices described a similar road taken to develop their relationships that included co-location of providers, a focus on fitting-in to the PC culture and clinic, and then a sense of having arrived at a mutually respectful and collaborative relationship where providers knew each other professionally and personally. However, while this study describes the patterns of the interprofessional collaborative relationship development, it falls short of helping us to understand what and how the team propels itself forward.

While the stages of the interprofessional relationship building process in a CMHC program have not been described previously, Chidambaram and Bostrom (1996) conducted a review of group development models. These authors described two broad types of group development, sequential and non-sequential. In health care, most authors describe team development using a sequential linear progressive model where the team matures and is defined by improved performance over time (Heinemann, 2002). Tuckman and Tuckman and Jensen's sequential lineal progressive model that includes five stages of development: forming, storming, norming, performing and adjourning (Tuckman, 1965; Tuckman, 1977) is widely accepted by experts of small group processes. Moreover, this team developmental theory has been used to describe interprofessional health care team development (Drinka & Clark, 2000; Farrell, Schmitt, & Heinemann, 2001; Hammick, Olckers, & Campion-Smith, 2009). However, while the study participants described that interprofessional collaborative relationships develops

over time, the participants in this study also describe the critical role of the regional leaders in the interprofessional team development.

In our model the regional leaders play an important role in the first two stages: Looking for Help and Initiating Co-location. Organizational leaders have long been recognized as an essential element to successful interprofessional collaboration. For example, San Martin-Rodriguez, Beaulieu, D'Amour, and Ferrada-Videla (2005) reviewed theoretical and empirical studies to determine the components for successful collaboration. These authors found that when the organization believes in interprofessional collaboration i.e., identify and/or understand the need for collaboration and create physical proximity between providers are among the important features necessary for interprofessional collaboration. D'Amour and Oanadasan, (2005) also suggest that the organizational leaders or decision makers must be supportive and play an important role in implementing interprofessional collaboration.

The participants in this study describe *fitting-in*, where the mental health care provider fulfills the PCP's patient needs by sharing their clinical expertise. As the PCPs recognize that their patient needs are being met, all providers begin to respect, trust and value one another, similar to the "norming" process that is Tuckman's third stage of group development (Tuckman, 1965). In a recent study, Benzer et al. (2012) reported that when mental health care providers in PC settings attend to the PCPs identified patient needs, communication between the PCPs and mental health care providers increased. While Benzer's work makes an important contribution to our understanding of interprofessional communication, it was not describing developmental stages nor grounded in health care providers' experiences.

The fourth stage of our proposed relationship building model, Growing Reciprocity includes descriptions of increased cohesion, a sense of trust, belonging, and togetherness. Cohesion is reflected in the study participants' discussion of comfort, trust, respect, sharing of values, and valuing of differences in opinion amongst providers. Cohesion, is thought to be an essential feature of group performance (Evans & Dion, 1991; Gully, Devine, & Whitney, 1995) and was identified as a key component of interprofessionality (D'Amour & Oandasan, 2005; Clement, Dault, & Priest, 2007). While several participants in this study discussed the importance of cohesion, further research would need to be done to understand the role of cohesion amongst the interprofessional health care providers.

In our study, participants discovered that they all valued a patient focus and holistic care that addressed patient and provider needs. As the participants in our study worked together, they recognized that they needed to be flexible depending on the primary care context and the unique needs of the patient and/or provider. Participants described adapting their communication strategies, approaches and schedules to meet each other's and the patient's needs.

The two central components of our model, communication strategies and the patient-centred approach have been reported findings of several previous studies. A commonly reported findings is the importance of providers communicating openly aiming towards reciprocal dialogue (Brown et al., 2002; Doey et al., 2009; Farrar et al., 2001; Goossen et al., 2008; Haworth et al., 2004; Kates, Craven et al., 2001; Kates, Crustolo et al., 2001; Kates et al., 2004; Kates et al., 1987; Kates et al., 1997; Kates et al., 2011; Mulvale et al., 2008;) while Lucena and Lesage (2002), discuss the importance of

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written communication strategies. In support of the second key finding, authors describe how a focus on the patient may assist teams in dealing with role conflict (Brown et al., 2002; McElheran et al., 2004; Mulvale & Bourgeault 2007). Team conflict is often a result of role boundaries, scope of practice, and accountability. However, in our study providers focused on providing patient focused care where the PCP requested interprofessional collaboration based on the patient's identified need for mental health services. Rather than focusing on areas that are the typical sources of conflict, such as role boundaries and scope of practice (Brown et al., 2011), providers in our study recognized that consideration of all of the perspectives may best meet the patient's needs. Maintaining a patient focus helped providers in our study to not categorize the varying opinions as "correct" or "incorrect", rather they were understood as a reflection of various professional knowledge and expertise. The Canadian Interprofessional Health Collaborative established interprofessional communication and patient-centred care as foundational competencies for interprofessional collaboration (The Canadian Interprofessional Health Collaborative [CIHI], 2010). Flattened hierarchy (Mulvale & Bourgeault, 2007) and flexibility (Paquette-Warren et al., 2006) have also been discussed in the shared care literature, although not conceptualized within a model that facilitates the interprofessional collaborative relationship building process.

Findings from our study make an initial contribution to our understanding of the developing interprofessional collaborative relationship between health care providers. More research is needed to understand how the components of the interprofessional collaborative relationships within a stage of development facilitate or impede team development. Future research may also explore the application of this interprofessional

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collaborative relationship building model to other practice settings. This collaborative

relationship building model highlights colocation of providers; future research may

explore virtual interprofessional collaborative teams and the processes they use to

develop their relationships. Other limitations of this study include the possibility that only

providers having positive interprofessional relationship building experiences volunteered

to participate in this study thus, limiting our understanding of the role of conflict and

conflict resolution. Furthermore, in this study the patient voice was represented by the

health care providers and not by the patient themselves. Future research on the

interprofessional collaborative relationships should include asking patients directly for

their perspective (Kates, Gagne, & Whyte, 2008).

Conclusion

Increasingly health care providers are asked to work collaboratively with their

colleagues from other professions. However, little attention has been given to how these

professionals are to initiate and maintain these interprofessional relationships. Providers

participating in CMHC programs within Canada, collaborate to successfully provide

mental health services in primary care settings. Exploring and documenting how these

providers develop and maintain their interprofessional collaborative relationships

contributes to our overall understanding of the importance of the provider-to-provider

relationship. Recognizing that relationships develop in stages and require time for

collaboration, may guide other health care providers to consider how they can

individually and collectively maintain a patient focus and use communication strategies

that are aimed at achieving greater reciprocity within their health care team. Ultimately,

understanding the characteristics of each developmental stage, the importance of co-

location, patient-focus, and communication strategies and the need to be flexible may position health care providers from a variety of professional backgrounds to successfully navigate the journey of developing relationships that may provide improved patient care.

Competing interests

Neither of the two authors have any competing interests to report.

Authors' contributions

PW and RLW contributed to the conception and design of the study. PW was responsible for all data collection. PW and RLW performed the data analysis and contributed to the drafting, reviewing, and approving the article. Both authors read and approved the final manuscript.

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CHAPTER 8: LOOKING FOR HELP PRIMARY CARE PROVIDERS' NEED FOR COLLABORATION TO DELIVER PRIMARY MENTAL HEALTH CARE SERVICES

Abstract

Primary care providers deliver the majority of mental health care to individual Canadians. Research suggests that these practitioners require collaboration with mental health specialists to better meet patients' needs. This study describes primary care providers' need for consultation and collaboration from mental health care specialists. The theme, Looking for Help is explained by three categories: My Comfort Zone, I Lack the Education, and Not Enough Time. Findings from this study may contribute to understanding primary care providers' need for consultation and collaboration with mental health specialists and provide a foundation to build collaborative mental health care practice.

Introduction

Internationally, primary care providers' (PCP) role in mental health services delivery is recognized (World Health Organization [WHO], World Organization of National Colleges [WONCA], 2008). PCPs including family physicians (FP) and nurse practitioners (NP) are integral to Canada's mental health system because they provide the majority of treatment to those who have mental illness (Lesage, Goering, & Lin, 1997; Lin & Goering, 1999; Rhodes, Bethell, & Schultz, 2006). Parikh, Lin, and Lesage (1997) conducted a secondary data analysis study using the Ontario, Canada Community Health Survey data, and found that two-thirds of individuals who sought mental health care included their FPs as treatment providers. More recently, Watson, Heppner, Roos, Reid,

and Katz (2005) conducted a population-based cohort study in central Canada using secondary data analysis. These authors reported that 92% of individuals treated for mental illness saw a FP and 47.3% of these individuals saw both an FP and psychiatrist. Comparing reported FP visits by individuals with a mental illness from 1992-1993, to visits from 2000-2001 there was an increase in those who exclusively saw their FP. Not surprising, there was a complementary decrease in those individuals with a mental illness who saw both an FP and psychiatrist. These same authors reported that FPs are providing more mental health services and that 30%-40% of individuals who visit their PCP have symptoms of a mental health illness. Fleury, Bamvita, Aube, and Tremblay (2010) conducted a survey of 398 general practitioners. Most of these practitioners reported following those with common mental disorders, anxiety and depression on a continuous basis. In this study, only FPs in walk-in clinics reported not following individuals with common mental disorders. Moreover, individuals with common mental disorders typically accessed only a PCP for service.

There is an increasing number of FPs adopting a focused area of practice in mental health services. Researchers reported that 12.1% of FPs' practice focus on mental health, the fourth largest reported area of focus (Canadian Medical Association [CMA], College of Family Physicians of Canada [CFPC], & Royal College, 2013). While PCPs do provide the majority of mental health care, there has been some concern about their ability to accurately diagnose mental illness (Kessler, Lloyd, Lewis, & Gray, 1999; Simon & VonKorff, 1995), prescribe appropriate medications (Swenson et al., 2009), and provide the required counselling services (Roy-Byrne et al., 1999; Goisman, Warshaw, & Keller, 1999; Wang, Langille, & Patten, 2014) within the primary care environment.

PCPs not only need to be able to diagnose mental illness, but they must also be able to detect severity (Kronke, Spitzer, & Willams, 2001) and provide the appropriate intensity of treatment and follow-up services (Simon, 1998).

Furthermore, researchers have reported PCPs' self-perceived barriers to delivering mental health care in primary care settings. PCPs describe their lack of comfort treating particular patient groups (Anthony et al., 2010; Benzer et al., 2012), and their feeling constrained by the current fee-for-service remuneration model (Henke, Chou, Chanin, Zides, & Scholle, 2008). Few of these studies have used qualitative methodology to capture a more in-depth understanding of the PCPs' experiences providing mental health care (Craven, Cohen, Campbell, Williams, & Kates, 1997), and there is little research that includes the perspectives of nurse practitioners (NP).

To improve timely access to mental health services, collaborations between PCPs and mental health specialists have been initiated across Canada (Macfarlane, 2005). While there are a variety of programs intended to facilitate mental health services being provided in primary care such as, Collaborative Mental Health Care (Kates, Mazowita, Lemire, Jayabarathan, Bland, Selby et al., 2011), Rapid Access Consultation to Expertise (www.raceconnect.ca), and primary care networks, this study focused on what Kates et al. term Collaborative Mental Health Care (2011). The intent of these collaborations is for providers to develop relationships within which they learn from one another to deliver care (Kates, Craven, Crustolo, Nikolaou, & Allen, 1997). In planning for increasing access to mental health care in primary care settings it is critical to understand the PCPs' self-perceived barriers to delivering optimal primary mental health care services.

Thus, the purpose of this qualitative study was to gain an understanding of how PCPs and mental health providers collaborate to provide mental health care in primary care settings. In Wener and Woodgate (2016) we presented a model that described how providers proceeded through four stages to develop interprofessional collaborative relationships to deliver primary mental health care. In stages one and two of the model, PCPs, mental health care providers, and program leaders identified the need for interprofessional collaboration and then initiated co-location of providers into primary care clinics and fee-for-service practices. During stage three of the model, fitting-in, mental health care providers worked to meet the PCPs' needs by sharing their diagnostic, medication management, and counselling expertise with the PCPs. Through this process of fitting-in, providers entered the last stage of the model, where they developed a mutually collaborative relationship and their relationships were becoming increasingly more reciprocal.

This paper expands on the findings of the first stage of the interprofessional collaborative relationship building model (Wener & Woodgate, 2016), this paper focuses on what prompts PCPs' to seek mental health care providers expertise to provide care. Attention is given to the PCPs' contextual barriers, that may inform future development of collaborative mental health care practices specifically and primary care networks more broadly.

Methods

In the larger study by Wener and Woodgate (2016), a grounded theory approach was used to understand the experiences of health care providers' interprofessional collaborative relationship (Charmaz, 2006). Further analysis of the FPs' and NPs'

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individual interviews was done to further explore the PCPs' emergent description of their experiences. The University of Manitoba Research Ethics Board provided ethical approval for this study. Informed consent was obtained from participants prior to the commencement of all individual interviews.

Participants

Recruitment flyers were distributed to all 110 PCPs, 100 family physicians (FP) and 10 nurse practitioners (NPs) that participated in a primary care collaborative mental health program in an urban centre located in Central Canada. We sought to recruit providers who varied in age, gender, practice site within an urban centre, and the FP remuneration model, fee-for-service (FFS) and salaried from the region (SFR). In keeping with grounded theory, sampling continued until no new codes or categories emerged (Charmaz, 2006).

Data Collection

A participant demographic self-report form was used to collect social demographic information. Between March 2011 and February 2012, the first author (PW) conducted 16 semi-structured 60-minute individual interviews. The interview guide included open-ended questions about the patient population served and their experiences providing mental health care. Sample questions include: 1) Can you describe your primary care practice population? and 2) Can you tell me about your experiences providing health services to patients with mental health problems?

Data Analysis

Descriptive statistics were used to analyze the socio-demographic questionnaires. Individual interviews were digitally audio recorded and transcribed verbatim. To achieve

the goal of further understanding of the PCP's need for interprofessional collaboration with mental health specialists, further analysis of the 16 individual in-depth interviews was conducted by the student researcher. While grounded theory entails reaching a theoretical rendering, this analysis was intended to describe the participants' perspective, remaining close to the data (Charmaz, 2014). The further data analysis process included re-reading the memos written for each interview and comparing memos noting similarities and differences within and between memos. Memos were then sorted into initial categories. The memos were then sorted and codes were entered into the existing coding table, while remaining open to new and emerging codes (Charmaz, 2006). The coding table included category definitions and example participant quotes to support the category. Similar initial categories were grouped and then collapsed to form the overarching theme and three categories. Interview transcripts and a newsletter describing the preliminary findings were mailed to all study participants for feedback prior to the finalization of the categories. Findings were also discussed with the thesis advisor.

We attended to trustworthiness by including triangulation of researchers, member checking, and creating an audit trail (Shenton, 2004). Trustworthiness was further established by aligning data collection methods with the study questions (Wener & Woodgate, 2013).

Results

Demographics: 16 PCPs participated in this study including, 10 (62.5%) females and 6 (37.5%) males who varied in age from 30-65 years and who practiced in a variety of primary care clinics within the health region.

Seven (43.75%) of the PCPs participated in the provincial FFS remuneration program where FPs submit billings for patient visits and receive payment from the provincial health department, while the remainder of FPs were SFR. All NPs receive a yearly salary from the regional health authority. In total, more physicians (n=11, 68.75%) FFS (n=7, 43.75%) and SFR (n=4, 25%) participated in this study than NPs (n=5, 37.5%). However, only 11 out of 100 or just over 10% of eligible FPs participated in this study whereas, 50% of eligible NPs participated in this study. As well, more female PCPs (68.75%) than male PCPs (37.5%) participated in the study. Overall, FFS FPs were older and graduated earlier than both the SFR FPs and the NPs. The SFR FPs tended to be younger than the FFS FPs and NPs.

Qualitative Analysis: The overarching theme of Looking for Help emerged from the data. Looking for Help is when the PCPs look to mental health experts to work with PCPs to help them to deliver mental health care in their primary care settings. This overarching theme describes the experience of when the patients' needs are beyond the PCPs' knowledge, skills, and comfort, and how this triggers the need for collaboration with mental health care providers. This FP describes the circumstances that prompt looking for help from mental health experts:

> …I'm unsure of the diagnosis, or my treatment hasn't worked, it is something other than anxiety and depression **…**so if I'm really uncomfortable, I'm not sure if I'm missing something else, I consult. …if I don't know when I'm talking to the patient, I'm not sure where I'm going with that, that's a great reason (to consult with a mental health specialist), but mostly it's (consultation) for when it's not working. I've tried a psychiatric medication which seemed appropriate, but it's

not going anywhere or we've tried multiple medications and we're not moving

forward, and then I would tend to consult. (FP5)

This overall theme is further explained by three emergent categories: My Comfort

Zone; I Lack the Education; and Not Enough Time. The PCPs described their experiences

looking for help in the context of wanting to provide patients with care that is consistent

with best practices. The categories held true for all participants regardless of their

professional background or remuneration model. However, there were some differences

between the FPs who had been in practice for more than 20 years and the other FPs and

NPs. While the authors have integrated the participants' quotes to illustrate each

category, due to the length of the manuscript quotes were shortened using the ellipsis (…)

while retaining the participants' overall intent. Pseudonyms are used in this manuscript to

provide confidentiality to the study participants.

Category one, My Comfort Zone is about PCPs self-perceived capacity to deliver

mental health care in primary care settings without accessing mental health specialists.

Most of the participating PCPs shared their ease working with *straightforward* patients,

those who present with depression or anxiety and who are responsive to medication or

counselling.

> Straightforward depression is fairly easy to treat most of the time…Some of
>
> them it's more straightforward that they just probably biochemically need some
>
> medication and they may or may not need counselling at that time… But yeah
>
> the same for depression and anxiety, I find fairly easy to treat. (FP4)

The PCPs also described that as they gained more primary care experience they

developed increasing comfort delivering mental health care to patients with depression

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and anxiety, "…years ago, I had a lower threshold of comfort with a lot of these things (mental illness), just for lack of experience when you're just right out of medical school… I think you get better as you pass time…" (FP1)

However, PCPs were similarly clear in their expression of discomfort when patients present with mental illness, multiple life issues, co-morbidities, are not responsive to treatment, and when there is an unclear diagnosis.

So yeah diagnostics for sure and complex medications, actually there's one patient where I just said like I'm not comfortable managing him at all, I need you to manage his medications, cause he came from out of town somewhere and he had a psychiatrist that managed him for like ten years, he came in the city, he was homeless, he had all these legal problems, he had no family in the city, he's got FASD (Fetal Alcohol Spectrum Disorder) or FAS (Fetal Alcohol Syndrome), probably schizophrenia as well, a violent history… (FP8)

Study participants expressed difficulties working with individuals diagnosed with personality disorders. The PCPs described their difficulties as a lack of knowledge and skills needed to be able to help patients to move forward in their lives. For example, some of the study participants explained that they had often diagnosed these patients as having depression, unaware of them having a personality disorder.

The ones I feel less comfortable with would be the probably the borderlines, and I, but I think some of those I haven't, I've only, some of them I've only recently sort of become aware that that may be their issue, so some of them I've been treating for depression for years and they're never really getting better and you've tried all

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different medications, and some of them have been seeing different psychiatrists.

(FP4)

Although some PCPs were comfortable managing patients with schizophrenia and bipolar illnesses, most PCPs were very clear in stating that they did not have experience working with people with these diagnoses and that they were uncomfortable offering treatment:

> I'm probably not very comfortable with schizophrenia. We don't see enough of it
>
> that…I don't have enough knowledge with or I'm just, I'm just not comfortable
>
> with and I guess bipolar is also another area that we don't manage all that, it's just
>
> an area that I haven't done a lot in and I'm just not as comfortable with, so those
>
> would be the type of things I engage the psych people. (FP2)

Participants perceived a need to engage or collaborate with mental health specialists to increase their level of comfort and to provide a broader range of needed services such as counselling. As this FP described, by collaborating with mental health care specialists, PCPs can comfortably offer mental health care to a wider range of patients, including those who may be perceived as difficult, as well as offering counselling sessions to patients who can benefit from this additional health care service.

> …the difficult ones are, the ones where I really feel you want them to see a
>
> psychiatrist, are the ones with depression, the ones where you think there's,
>
> borderlines, that don't respond simply to medication. And then you know, as far
>
> as counselling, I mean there's a lot of people who require counselling …there are
>
> people who require some counselling with regards to how they're responding to

the stresses in their life and that's the nice part of having somebody (to collaborate with onsite) so you don't have to go looking for a psychologist. (FP15)

Category two, I Lack the Education is about the PCPs need for help because their educational background and experiences did not prepare them to independently deliver mental health care in primary care settings. While all of the study participants described being educated to be generalists, there was some sense that their education did not adequately prepare them to provide mental health care. The lack of preparation was particular noted by those study participants who had been in practice for more than 20 years. For example, an FP who had been in practice for over 25 years expressed that education about mental illness and treatment was not a major focus in medical education programs: "… in part quite honestly I think in my case the teaching in mental health issue was woefully lacking." (FP16) Although the NPs did not identify an overall lack of attention to mental illness in their educational programs, this NP described the limits of the educational program, "…I mean I've got one person in my practice that I've hung onto but those patients require a higher level of expertise than I'm prepared with in my educational program." (NP11)

PCP participants discussed how they could increase their knowledge and training about delivering mental health services by attending continuing education sessions. However, only a few PCPs reported that they had attended these educational sessions. Those participants that did attend these sessions reported the impact on their practice. For example this participant attended a session to learn more about personality disorders and came to realize that this was perhaps the issue for some of the patients that he had not recognized prior to receiving this education:

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…we just had a couple of educational things on personality disorders … there's

absolutely no doubt in my mind the other ones where you sort of look and think

okay this is part of the problem, and so I definitely think that I have a few of

those. (FP3)

While participants recognized their lack of education about and the value of

training of specialized approaches such as, cognitive behavioural therapy (CBT), they did

not all perceive this as an area in which they should be trained.

I'm not trained in cognitive behaviour therapy, I can sit and counsel and talk to

people and sort of work them through certain things, but there's different

techniques and different things that the mental health workers do that is a real sort

of valuable add-on to what we have… (FP2).

Study participants were also aware of no cost evening and weekend educational

sessions designed to increase their knowledge and skills in providing primary mental

health care. However, PCPs had difficulty attending these due to competing schedules

and family life. Many of the PCPs participating in this study explained that while they

believed the educational sessions would be useful, they were unable to attend, "Yeah

they're very useful yeah, but it really depends, as you know usually they're after hours

and I find it difficult to kind of reconcile that with my, with my large family...." (NP10)

Rather than attending continuing education sessions the PCPs talked about the

value of collaborating with mental health specialists who could provide education that

focused on particular cases.

It's (educational evenings) not a priority for me… I want to know about new

medications and things like that but you know I, I've done this like 20 years…

what is helpful is being able to sort of talk one-on-one about a specific case (with the mental health specialist), that's helpful, but to go and sit in a lecture about depression, no. (FP15)

The participants also talked about learning through their previous experiences and how working through some of the more difficult situations was helpful for future understanding.

…so I think you get better as you pass time and you remember the things that burnt you in the past where you've actually could have done a better job and realized it and you're not going to let that fool you the next time. So you know you build on things that are based on experience so. (FP1)

Category three, Not Enough Time is about the PCPs perception that patients with mental illness want and need counselling that requires more time than the NP or FP can provide. PCPs believed that their practices were driven by time rather than quality and that patients with mental illness required more care time than the PCP could afford, leaving PCPs wondering who they could collaborate with to fulfill this patient need. For some PCPs, the lack of time was about the FFS remuneration model that requires physicians to see many patients and to see them quickly. As this physician explained:

The big problem with family medicine and psychological problems is that they're time consumers and unfortunately the way the system is set up, it is time driven and your remuneration is based on how many patients you see in a day…They punish you for doing a good job and they reward for doing a very quick and superficial job, that's the way it works, it's sad but it's true. (FP1)

Study participants who are remunerated through a SFR model where they received a yearly salary, also found that although they could provide a 15-minute appointment time, they were not able to provide patient-focused service to their patients with mental illness, especially if the patients wanted to talk with them or be counselled. This SFR FP explained:

> …and a lot of the time I get the sense that they really want to talk to me and to be listened to and then, and then of course that's, as an MD there's some time for that, but not really, not enough time to really do that justice…. (FP6)

Unlike the FPs, NPs in this study provided 30-minute appointments that they perceived as more fitting to the patients with mental illness.

> …that's great for most mental health appointments because I think usually on a single initial encounter I can usually diagnose and initiate treatment and actually have the opportunity to actually talk to the patient about you know background, there's a lot of opportunity there, and actually I find, I find those half hour appointment times most appropriate for mental health issues. (NP10)

However, although this NP expressed that the 30-minute appointment was a good fit for patients with mental illness, the same NP explains that time restriction limits care to providing medications:

> I guess not unlike physicians most of my role in mental health revolves around medication, to a smaller extent you know counselling, but that's the minor extent of it cause again like the physicians my, my time is limited to… (NP10)

In their attempts to provide patient focused care, providers felt pressure to offer services to their patients with mental illness that were beyond their knowledge and/or

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time capacity. Study participants believed that getting help from specialists might relieve this pressure.

> I think with the patients what I'd like to devote in terms of time to them sometimes doesn't translate into the time we have in a day, just like we were saying before you only have a certain number of hours in a day. I'd love to be here 24/7 but unfortunately there's other demands that you get stretched and pulled for as well, and with that I think sometimes you need more specialized care and more specialized help. (FP13)

Discussion

In our study, PCPs discussed providing primary mental health care while at times feeling uncomfortable, ill prepared educationally, and constrained by time to provide optimal care to their patients. The participants in our study described their comfort providing services to those with depression and anxiety that are responsive to treatment, while feeling uncomfortable providing treatment to those with major mental illness such as bipolar disorder. While Sherman, Gilliland, Speckman, and Freund (2007) reported that PCPs feared being overwhelmed treating those with depression, other authors reported results similar to ours; PCPs mostly treated those with anxiety and depression (Craven et al., 1997). Mitchell et al. (2006) presented the role of FPs in treating Schizophrenia and Bipolar disorder; however this author did not go beyond description of study effectiveness. Consistently, the participants in our study described having difficulty diagnosing and being uncomfortable working with patients who have a borderline personality disorder. People with this diagnosis are thought to be difficult to treat (Gross et al., 2002).

Some authors have reported that FPs' overall dissatisfaction with the quality of mental health care they are able to provide (Clatney, Macdonald, & Shah, 2008). Other authors who have reported results similar to our study have suggested that developing PCP mental health specialist collaboration may alleviate PCP discomfort working with patients who present with complex mental health illness (Fickel et al., 2007).

There has been increased attention to the lack of education FPs receive about mental health. In particular, only 60% of family practice residency program directors were satisfied with the amount of psychiatry education their residents receive (Leigh, Stewart, & Mallios, 2006). NPs reported that although mental health was a primary practice concern, 80% felt they were not equipped to treat mental illness (Elsom, Happell, & Manias, 2005). FPs in Saskatchewan reported that education in mental health care needs to become an area of focus (Clatney et al., 2008). Participants in our study preferred education that was specific to their cases and for the most part did not attend formal evening educational sessions. Similar to the findings in our study, the WHO and WONCA recommend that in order to successfully integrate mental health services into primary care, joint consultations between PCPs and specialists is an effective and practical means of education (WHO et al., 2008). However, other researchers have reported that educational strategies such as case consultations and didactics did not improve patient outcomes (Lin et al., 1997). Sherman, Gilliland, Speckman and Freund (2007) implemented an educational program within a newly created primary mental health care collaborative service. These authors suggested that PCPs required education on collaborative care, as well as information focusing on managing mental illness such as depression.

The findings about comfort and education from our study conducted in an urban

centre in central Canada are consistent with those studies conducted in eastern Canada

(Farrar, Kates, Crustolo, & Nikolaou, 2001; Fleury et al., 2008; Fleury, Bamvita, &

Tremblay, 2009; Rockman, Salach, Gotlib, Cord, & Turner, 2004). Similar findings may

be due to the consistency in training within the physician and nurse practitioner education

programs across the country. For example, the Canadian College of Family Physicians

determines the educational and practice requirements for all physicians completing a

residency in family practice in Canada (College of Family Physicians of Canada [CFPC],

2015) and the Canadian Nursing Association offers a core competency document that

outlines the requirements for all Canadian nurse practitioners (Canadian Nurses

Association [CAN], 2010). Furthermore, few NP or FP trainees receive education from

mental health experts in primary care settings. Rather, most mental illness training

typically occurs in tertiary care facilities where patient presentation and resources

available to treat patients are different (Parikh et al., 1997; Wasylenki et al., 2000;

Cochrane et al., 2000).

Time was consistently identified as a barrier to providing primary mental health

care and has been reported previously by other researchers (Craven et al., 1997; Henke et

al., 2008; Sherman et al., 2007). Henke et al. (2008) reported that physicians did not have

the same amount of time as counsellors to provide treatment, having just enough time to

make a diagnosis and prescribe medication. Similar to other studies, the participants in

our study identified a lack of time to provide counselling as the most common

constraining issue (Benzer et al., 2012; Fickel et al., 2007; Henke et al., 2008). However,

these same authors reported that many FPs in their study routinely put 30 to 60 minutes

aside to provide counselling to some patients.

Anthony et al. (2010) found that one-third of their PCP study participants did not consider the patients' emotional problems because of perceived time limitations. When an FP suspects that a patient may be experiencing psychosocial problems, some FPs consider the time constraints when deciding whether or not to question patients about their mental health. Participants in other studies perceived time constraints to be due to patient volume, whereas the participants in this study thought that the remuneration model was the barrier, rewarding those who spend less time with their patients. Three different types of FP remuneration are commonly implemented across Canada: 1) FFS with an incentive to provide high quality billable services, 2) capitation, where FPs are provided a fixed payment per time period and per patient, and 3) salaries, where FPs receive a fixed payment that is not related to patient volume (Wranik, Hanrahan, & Tarrant, 2012). In the current study it was only the FPs who discussed that remuneration was a barrier to working with individuals with mental illness. However, in the context of collaborative care, authors of a recent study concluded, "when patients were attached to a team of providers and funded on a per patient basis, shared care and collaboration were encouraged" (Wranik, Korchagina, Edwards, Bower, Levy, & Katz, 2015, p.33).

Limitations

This study included FPs and NPs who were already participating in a collaborative care or shared mental health program and may represent a particular group of PCPs. Furthermore, the participants in this study may have perceived that they would benefit i.e. receive even more access to mental health specialists if they described issues that may be attended to within a collaborative mental health care service. The purpose of

qualitative research is to provide results that are grounded in the participants'

experiences. As only 10% of FPs participating in the collaborative program participated

in this study, the findings must be interpreted with caution and cannot be generalized to

other FPs participating in the collaborative mental health program. Although the study

participants included a small number of NPs this profession is relatively new and only a

small number of individual NPs are engaged in this Collaborative Mental Health Care

program. Furthermore, PCPs in this same urban centre who did not have access to mental

health specialists may or may not be looking for help for reasons other than a lack of

comfort, education, and time. To provide a broader perspective regarding the PCPs' need

to deliver of mental health care in primary care settings, future studies should gather data

from mental health experts to understand how they contribute to collaborative mental

health care. This qualitative study reflects the findings of these study participants in this

particular urban centre. However, as other Canadian researchers have reported similar

findings, future work in this area may focus on developing pre-licensure educational

interventions to increase NPs and FP residents' comfort, knowledge and skills of mental

illness. In addition to focusing on education, the study findings may inform primary care

network development by highlighting the importance of understanding the PCPs'

consultation needs and current barriers they face. If primary care networks are to be

successful, consultations must fit the PCPs' needs and barriers to consultation must be

removed.

Conclusion

The participants in this study described the issues that prompt their need for help

in order to provide optimal primary mental health care. Many of the PCPs expressed that

they needed help to increase their comfort, knowledge, and experience to provide high quality primary mental health care. Study participants also described that their usual 15 or 30-minute appointment times were not well suited to all patients seeking primary mental health. More specifically, participants recognized that mental health specialists have more time and expertise to provide evidence-based therapy, such as cognitive behavioural counselling. The similarity of the findings from this study with studies conducted in other parts of Canada, suggests that the issues described here permeate the Canadian primary care system. As we move to create primary care networks, we must consider increasing PCPs' mental health care competencies via pre-licensure education, while simultaneously attending to the PCPs' needs for consultation with mental health specialists.

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CHAPTER 9: CONCLUDING CHAPTER

This final chapter presents the knowledge translation (KT) activities associated with this study. Based on the study findings, the recommendations for practice, education, and research are presented for consideration.

Knowledge Translation Activities

The Canadian Institute for Health Research describes knowledge translation in health care as a knowledge-to-action cycle that includes both knowledge creation and knowledge-to-action. The knowledge translation (KT) activities associated with this study were end-of-grant, that are aimed primarily at knowledge creation.

As this qualitative study was an iterative process where data collection and analysis were conducted simultaneously, KT was integral to the process and was provided throughout the study from 2011-2016. KT involved presentations to and feedback from participants and stakeholders. Activities were created for a variety of knowledge users and different approaches to KT were used for the varying knowledge users. Some KT activities, such as the preliminary findings and emergent model were widely distributed, while other KT activities were specifically created for academics or practice-based knowledge users.

After conducting and analyzing 16 individual PCP interviews, the findings were distributed through two newsletters, a peer-reviewed paper presentation, and a poster (Appendix M: Wener, Woodgate, Goossen, & Jones, 2012) in May 2012 through November 2013. The newsletters were distributed to all study participants as part of a member-checking process (Charmaz, 2006), CMHC program leaders, Shared Care Counsellors, mental health and primary care decision makers, University of Manitoba Department of Family Medicine, Winnipeg

Regional Health Authority Occupational Therapy Professional Lead group as well as, the thesis dissertation committee.

The poster was presented at two peer-reviewed conferences: one international and one national. The paper presentation was given at an international conference. The international conferences were aimed at knowledge users who are interested in interprofessional collaboration in general, while the national conference was specifically aimed at knowledge users interested in CMHC. The poster was also presented locally to the Regional Health Authority Shared Care Counsellors at a team meeting and to the Regional Health Authority Collaborative Mental Health Care and Primary Care Leadership group.

An update to the first newsletter was created and distributed to all of the study participants and the CMHC program counsellors and leadership group as well as the dissertation committee in September 2013 (Appendix N). This newsletter provided a graphical representation of the findings after the first 16 individual and 6 group interviews were conducted and further analyzed.

These KT activities provided opportunity to discuss this study and the early findings with many stakeholders and interested individuals. The feedback received from the individuals was used to revise the interview guide for the focus groups and individual interviews of program leaders. For example, several knowledge users confirmed that a direct question about conflict and conflict resolution was required, as participants did not sufficiently discuss this issue during the initial 16 individual interviews; this line of questioning was added.

After conducting and analyzing the PCP individual interviews and the team and leadership interviews, further KT activities occurred. A web-based presentation that included Power point slides with voice-over was created using Articulāte Storyline®. This presentation

was duplicated onto USB flash drives that were provided to all study participants, dissertation committee members, all PCPs who are participate in the CMHC program, health care decision-makers at the Regional Health Authority, all CMHC counsellors and a wide variety of other stakeholder and interested individuals. Examples of other stakeholders included an 18 member allied health leadership group, 20 occupational therapy students entering fieldwork placements in primary care, a national leader in interprofessional collaboration, University of Manitoba professors and instructors, regional directors of both mental health care and primary care. Six peer-reviewed presentations, six national, and two international were given between June 2013 and June 2016. Conference attendees included researchers, health care practitioners, and health care consumers, knowledge users interested in interprofessional collaboration, primary care, or CMHC programs. An additional six invited presentation were given to a wide ranging group of knowledge users including the Canadian Dental Hygiene Association, an interprofessional collaboration community of practice, and the Winnipeg Regional Health Authority Professional Advisory Council to name a few.

The manuscripts in Chapters four and seven have been published in peer-reviewed journals. The manuscript contained in Chapter four provided an opportunity to share the study focus and research plan for this study with the interprofessional collaboration research and academic community. As part of a competition for the 2013 "best article," this manuscript was further reviewed and analyzed in an article published within a later issue of the journal. The later article provided further opportunity for knowledge translation related to designing robust research that will make a contribution to the field of interprofessional collaboration.

As an end-of-grant KT activity, a summary of this study and emergent grounded theory are contained in Chapter seven. To improve access and KT, this manuscript was published in an

international peer-reviewed, open access journal that is accessible using search engines that are commonly used by the general public, such as Google or Yahoo. The open access format allows a wide range of knowledge users to have easy access to the study findings manuscript. Knowledge users may use the presented interprofessional collaborative relationship building model as a teaching tool to help those working in similar context to navigate their relationships. Chapter 8 includes a manuscript that focuses on the first stage of the relationship building model, Looking for Help. This manuscript was submitted to the Canadian Journal of Community Mental Health and is currently under revision. One additional manuscript that focuses on the other three stages of the relationship building model: Initiating Co-Location, Fitting-in, and Growing Reciprocity is planned for, upon completion of the student researchers' doctoral studies. Further KT activities specifically aimed at the knowledge-to-action cycle will be planned post-doctoral studies.

Recommendations for Practice, Education and Research

Recommendations for Practice

The emergent findings of this study included a model that may be used by health care leaders and providers to navigate the complexity of developing interprofessional collaborative relationships in primary care. As the number of health care providers working in primary care to deliver mental health services is expanding to include pharmacists, dieticians, youth counsellors, addiction counsellors to name a few (Kates, McPherson-Doe, & George, 2011), a roadmap to negotiating these interprofessional relationships becomes increasingly important.

The Interprofessional Collaborative Relationship Building Model highlights the need for providers to have time to develop their inter-provider relationships. Program leaders must understand that relationship development requires time and should encourage providers to use

the model to facilitate their relationships from one stage to the next stage recognizing that time is required for collaboration. For example, as described in this study, providers were made aware of the program leaders' approval to take time to fit-in with the providers who require help. All providers also need to be aware that it takes time until the interprofessional collaborative relationships reach a stage where the interprofessional relationships are reciprocal.

The results of this study also support the need for the health regional leaders and health care providers to be flexible in their approach to interprofessional collaboration to ensure it fits with the needs of specific context and with an aim to improve patient-focused care. For example, when co-location of providers is not possible highlighting other modes of communication such as the telephone, EMR, or email may increase PCPs' timely access to mental health expertise.

Recommendations for Policy

FPs that participated in this study stated that they did not have the time to provide treatment to those with mental illness, given the remunerations models currently used. Given that PCPs in this study supported collaborative mental health care, provincial and territorial governments must consider the impact of using blended remuneration models (Wranik, Korchagina, Edwards, Bower, Levy, & Katz, 2015). These blended models have been shown to afford providers time to develop their inter-provider relationships and to treat individuals with mental illness. Blended payment models that include, incentives for providing care in priority areas such as mental health, are recommended (Hutchison, Levesque, Strumpf & Coyle, 2011). However, in those practices that are FFS, it is important to consider the need for time to provide mental health services in light of the 10-15 minute FP visit.

Recommendations for Education

PCPs in this study reported that they lacked knowledge and skills to provide mental health services in primary care settings when individuals are not responsive to medication. Currently, FP residents and NP students spend little time working directly with mental health experts. Further exposure to collaborative care with mental health experts during pre-licensure education is recommended. More specifically, prior to graduating from the NP or FP educational programs students need to gain experience with more complex and difficult to treat individuals with mental illness.

Post-licensure education needs to be meaningful to the providers. Education needs to be interprofessional and well-timed to meet the PCPs learning needs. In keeping with the recommendation from the participants from this study, education should be specific to the cases that the PCPs are currently treating.

Interprofessional providers working collaboratively are becoming the desired norm across Canada (Hutchison, Levesque, Strumpf, & Coyle, 2011). However, it is not enough to put groups of multiple providers from different professions together. Interprofessional collaboration requires education specifically focused on building collaborative relationships. It is recommended that NPs, FPs, counsellors, and psychiatrists learn about interprofessional collaboration including the Interprofessional Collaborative Relationship Building Model together, pre-and post-licensure. However, while researchers support the value of interprofessional education, physician attendance is often poor (Reeves, Freeth, Glen, Leiba, Berridge, & Herzberg, 2006). Program and physician leaders must role model and facilitate physicians' attendance at interprofessional education learning opportunities.

Recommendations for Research

Creating the Interprofessional Collaborative Relationship Building Model provided a theoretical understanding of how these study participants developed their interprofessional collaborative relationships. However, it is unclear if the model will be useful to CMHC practitioners and program leaders. Providers and leaders need to be educated about the model and then be engaged in research to determine the usefulness of the model.

Further interprofessional collaboration amongst health care providers is desired as part of primary care reform across Canada (Hutchison, Levesque, Strumpf, & Coyle, 2011). In addition to psychiatrists and counsellors, dieticians, pharmacists, and social workers, (Bayliss, Bhardwaja, Ross, Beck, & Lanese, 2011), occupational therapists (Donnelley, Brenchley, Crawford, & Letts, 2013), and psychologists (Pomerantz, et al., 2010) are being integrated in primary care practices. Given the likelihood of interprofessional collaboration amongst providers becoming more the norm than the exception, further exploration of blended remuneration models that support this type of primary care is recommended. Finally, future research should explore the utility of the Interprofessional Collaborative Relationship Building Model by other health care professionals who in addition to mental health deliver other aspects of primary care.

Strengths and Limitations

The study findings deepens our understanding about the need for interprofessional collaboration, the providers' experiences of interprofessional collaboration, building of their interprofessional relationships including the providers' opportunities and challenges of working interprofessionally to deliver mental health care in primary care settings. As the purpose of this study was to understand providers' experiences and ascribed meaning of interprofessional collaboration, the findings cannot be generalized to other groups of health care providers. This

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study focused on the interprofessional relationship between FPs, NPs, psychiatrists, and counsellors. Other health care providers who are co-located with the primary care providers such as foot nurses, or the primary care practice administrative staff were not included in this study and may have added to our understanding of interprofessional collaboration.

While this study makes an initial contribution to understanding interprofessional collaborative relationship building development, future exploration is required. Researchers may want to explore facilitators that promote the team members to progress from one stage to the next. Similarly, this study identifies the importance of cohesion amongst the team members however, further exploration of this component of the model is warranted.

As this is a qualitative study of collaborative relationship building amongst providers within a specific type of collaborative mental health care that is located in an urban centre, the findings cannot be applied to other settings. Further exploration is required to understand how this model may apply to interprofessional collaborative relationship development within other areas of chronic care disease management within primary care such as, management of diabetes, cardiovascular disease or chronic obstructive pulmonary disease. Similarly, future exploration is required to understand the application of this model to rural and northern primary care settings.

It should be noted that although there were seven focus groups the number of health providers per group was low and may have limited the focus group interactions and dynamics (Brown, 1999). Given that participants in this study did not identify the role of conflict and conflict resolution, the possibility that only providers having positive interprofessional relationship building experiences volunteered to participate in this study must be considered. The success of interprofessional collaboration amongst the providers in the CMHC program

indirectly represented the patient voice in addition to the provider voice. Future research should include patients and their perspective of interprofessional collaboration in CMHC.

Conclusions

This study makes an important contribution to our existing understanding of health care providers' experiences of interprofessional collaboration in CMHC. While earlier studies have described a need for providers to work together to deliver mental health care in primary care settings, few have focused on the interprofessional collaborative relationship. The emergent four-stage model presented further clarifies that building interprofessional relationships is a process that is facilitated by patient and provider needs and requires time to develop. The model highlights the need for collaboration, due to PCPs feelings of discomfort and perceived lack of knowledge and education required to provide mental health care in primary care settings. Future research may explore the application of this model to other CMHC programs or practice settings. The model may also be used to assist individuals or groups of multiple providers who are attempting to navigate their interprofessional collaborative relationships.

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APPENDICES

Appendix A: Initial Recruitment Email

Dear Nurse Practitioner or Physician:

In 2009, you volunteered to participate in a study to examine the impact of the Shared Mental Health Care program and a study evaluating the knowledge transfer process, taking place between the Primary Care staff and the Shared Mental Health Care staff. The recruitment for these two studies was very successful and due to time constraints, these studies ended before all primary care providers had the opportunity to participate. The research group from primary care and shared mental health care have reviewed the studies and preliminary results indicate that the Shared Care model is very successful in increasing access to mental health services and health care providers are generally pleased with the program. A report summarizing these findings will be available early in the new year.

At this time, we are initiating a new study that builds on the findings of the previous studies. This study will focus on the process of interprofessional collaboration between primary care providers and mental health care providers. In this study, we are exploring the process between primary care providers and mental health care providers. The model of shared care is innovative in Canada and we are interested in capturing the interprofessional process that occurs between primary care and mental health care. The ultimate goal of this study will be to construct a model that illustrates current practice. At this time, you are invited to participate in Phase 1 of this study that will involve an interview with a researcher. An honorarium to acknowledge your time and expertise is offered. Your participation in this research study is voluntary

If you are interested in learning more about the opportunity to participate in this study, please contact:

Researcher's Name: Pam Wener
Telephone Number: 204-789-3456
Email Address: pwener@cc.umanitoba.ca

Sincerely,

Pamela Wener
Principal Investigator
204-789-3456

Appendix B: Revised Recruitment Email for PCPs

Dear Nurse Practitioner or Physician:

In 2009, the Primary Care and Shared Mental Health Care programs conducted a study evaluating the knowledge transfer process, taking place between the Primary Care staff and the Shared Mental Health Care staff. The research group from primary care and shared mental health care have reviewed the studies and preliminary results indicate that the Shared Care model is very successful in increasing access to mental health services and health care providers are generally pleased with the program. A report summarizing these findings will be released and disseminated by the program.

As part of my PhD studies and with the support of the Shared Mental Health Care and Primary Care programs, I am initiating a new study that builds on the findings of the previous studies. This study will focus on the process of interprofessional collaboration between primary care providers and mental health care providers. In this study, I am exploring the process between primary care providers and mental health care providers. The model of shared care is innovative in Canada and we are interested in capturing the interprofessional decision making process that occurs between primary care and mental health care. The ultimate goal of this study will be to construct a model that illustrates current practice. At this time, you are invited to participate in Phase 1 of this study that will involve an interview with a researcher. An honorarium to acknowledge your time and expertise is offered. Your participation in this research study is voluntary

If you are interested in learning more about the opportunity to participate in this study, please contact:

Researcher's Name: Pam Wener
Telephone Number: 204-789-3456
Email Address: pwener@cc.umanitoba.ca

Sincerely,

Pamela Wener
Principal Investigator
204-789-3456

Appendix C: Research Participant Informed Consent Form for PCPs

Principal Investigator: Pamela Wener
R125-771 McDermot Ave.
Department of Occupational Therapy
University of Manitoba
Winnipeg, Manitoba R3E 0T6

Co-Investigators:

Dr. Roberta Woodgate Professor, Faculty of Nursing465 Helen Glass Centre for Nursing Faculty of Nursing University of Manitoba Telephone: (204) 474-8338	Ms. Jeanette Edwards Regional Director WRHA Primary Health Care Adjunct Professor, Department of Occupational Therapy, University of Manitoba PE 450 Riverview Health Centre 1 Morley Ave. Winnipeg, Manitoba R3L 2P4 Telephone: (204) 940-8575	Dr. Dieter Schönwetter Director, Educational Resources and Faculty Development D09-780 Bannatyne Ave. University of Manitoba Telephone: (204) 480-1302

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the study staff. You may take your time to make your decision about participating in this study and you may discuss it with your friends or family. This consent form may contain words that you do not understand. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of Study

The purpose of this qualitative study is to increase our understanding of interprofessional team collaboration in primary care. Specifically, this study will focus on the collaborations and health care decisions made by primary care physicians or nurse practitioners, referred to as the primary care providers (PCP) and psychiatrists or counselors referred to as mental health providers (MHP) in response to client's mental health concerns presented in the primary care setting.

Previous work carried out by the Regional Health Authority (WRHA) Primary Health Care and Shared Mental Health Care programs identified collaboration among health professionals, as one of the key facilitators contributing to the success of the current primary health care/shared mental health care joint service. This study will build on this previous work by focusing on decision making process that occurs by the health care providers when a patient presents with mental health concerns.

The research overall objectives for this study are:

1. To detail health care team members' perspectives and experiences of interprofessional decision making.
2. To identify how the individual (micro), professional and team (meso), and systemic (macro) conditions and interrelationships influence the decision making process that occurs in the context of shared mental health care.
3. To identify the opportunities and challenges of decision making in the context of shared mental health care.

This study will include 3 phases

- Phase 1 January 2011-January 2012- Understanding the need for collaborative decision making between PCP and MHP
- Phase 2 January 2012-January 2013- Exploring team collaboration at the micro and meso level
- Phase 3 January 2013-January 2014-Exploring the macro level policies and documents that support collaborative team decision making

At this time, you are being asked to participate in Phase 1 of this study. The objective of Phase 1 is to understand and detail for the need for collaboration between primary care providers and mental health providers. A total of 20 participants will participate in this study.

Study Procedures:
If you agree to participate in this study a research assistant will contact you by telephone or email to request your mailing address and to provide any information you may want about the study. If at this time, you indicate that you are interested in participating in this study, this informed consent form will be mailed to you at your worksite. After approximately one week, the research assistant will contact you by telephone or email, to arrange an interview time and location that is convenient for you. The interview will be conducted by the principal investigator and will be approximately 60 minutes in duration. The interviews will be audio recorded and transcribed verbatim. Once the interviews are transcribed, audio tapes will be destroyed. Interview transcripts will be sent to participants by email and participants will be invited to correct any inaccuracies. No identifying information will be on the interview data. All names on the transcripts will be pseudonyms. If you take part in this study, you will participate in the following: One 60-minute interview at a time and location that is convenient for you. The interview will be audio recorded and the transcript will be sent to you to correct any inaccuracies. The principal investigator will be conducting all interviews. The interview will focus on your experiences regarding the need for collaborative decision making between primary care and mental health care to meet the needs of your patients with mental health concerns.

You can stop participating in this study at any time. However, if you decide to stop participating we encourage you to talk to the study staff first.

Results from Phase 1 of the study will be sent directly to all participants by email in the form of a report that will reflect the collective results of all 20 interviews rather than individual results.

Risks and Discomforts:
There are no known risks or discomforts of participating in this study.

Benefits:

There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will benefit health care providers working in primary care and mental health care as well as, patients with mental disorders in the future.

Costs:
It is expected that all participants in this study will participate outside of their regular work time.

Payment for Participation:
All participants will be given a $100.00/ hour cheque for participation in the interview. This honorarium is to acknowledge the practitioner's expertise and time taken to participate in this research. Practitioners cannot be available to see patients during the time they are participating in this interview. For practitioners who have a fee-for-service agreement the time spent in the interview may represent a loss of income.

Confidentiality:
Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. Each study participant will receive a pseudonym that will be used on all study information including the Practice Information Form and interview transcripts. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All research information including informed consent forms, completed information forms and interview transcripts will be kept in a locked secure area in the Principal Investigator's office (R125-771 McDermot Ave. or T261B-770 McDermot Ave.) and only the study staff identified will have access to this information. If any of your research records need to be copied to any of the above, your name and all identifying information will be removed. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba

Voluntary Participation/Withdrawl from the Study:
Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from the study will not affect your employment by the WRHA. We will tell you about any new information that may affect your health, welfare, or willingness to stay in this study.

Questions:
You are free to ask any questions that you may have about the study and your rights as a research participant. If any questions come up during or after the study contact Pamela Wener at (204) 789-3456

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all your questions.

Statement of Consent:
I have read this consent form. I have had the opportunity to discuss this research study with Pamela Wener and or his/her study staff. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member) I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board, for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I agree to be contacted for future follow-up in relation to this study?

Yes____   No____

Participant signature _____Date _____
                                                                                         (day/month/year

Participant Printed Name: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent

Printed Name: _____   Date _____
                                                                                         (day/month/year)
Signature: _____

Role in the study: _____

Version date: January 14, 2011   Page 4 of 4   Initials ____

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Appendix D: Recruitment Email for Health Care Provider Groups

Dear Physician, Nurse Practitioner, Shared Mental Health Care Psychiatrist or Shared Care Counselor:

In 2009, the Primary Care and Shared Mental Health Care programs conducted a study evaluating the WRHA Shared Care program. The purpose of the evaluation was *1) to inform program improvement and decision making, 2) to document learnings on the implementation of Shared Care expansion into the fee-for-service Family Physician practices, and 3) to explore the clinical and operational elements of the Program that worked to support collaborative practice in primary care, and to inform decisions as efforts are underway to build the primary care system of the future.* The full report is available from: http://www.wrha.mb.ca/professionals/familyphysicians/files/SC_Eval_May5-2012.pdf

As part of my PhD studies and with the support of the Shared Mental Health Care and Primary Care programs, in 2011, I initiated a new study that builds on the findings of the previous studies. This study will focus on the process of interprofessional collaboration between primary care providers and mental health care providers. In this study, I am exploring the decision making process between primary care providers and mental health care providers. The model of shared care is innovative in Canada and we are interested in capturing the interprofessional collaboration process that occurs between primary care and mental health care. The ultimate goal of this study will be to construct a model that illustrates current practice. At this time, you are invited to participate in Phase 2 of this study that will involve meeting for 90 minutes with a group of your colleagues with whom you collaborate to provide mental health services and a researcher. All group interviews will take place at a location of your convenience. You are encouraged to share this flyer and invite all of the health care providers who are involved in the Shared Mental Health Care program at your health care clinic site. An honorarium to acknowledge your time and expertise is offered as well as a meal should the interview occur over the lunchtime. Your participation in this research study is voluntary

If you are interested in learning more about the opportunity to participate in this study, please contact:

Sincerely,

Pamela Wener
Principal Investigator
Telephone: 204-789-3456   Email: Pam.Wener@med.umanitoba.c

Appendix E: Recruitment Flyer for Program Leaders

Dear Program Directors and Managers

You are receiving this invitation because you have been identified as part of the Shared Care Mental Health Service Leadership Group. As part of my PhD studies and with the support of the Shared Mental Health Care and Primary Care programs, I initiated a study that builds on the findings of the 2009 program evaluation. This study will focus on the process of interprofessional collaboration between primary care providers and mental health care providers. In this study, I am exploring the interprofessional collaboration between primary care providers and mental health care providers. The model of shared care is innovative in Canada and I am interested in capturing the interprofessional collaboration process that occurs between primary care and mental health care. The ultimate goal of this study will be to construct a model that illustrates current practice. At this time, you are invited to participate in Phase 2 of this study that will involve meeting for 90 minutes that will include the Leadership Group and the researcher. The interview will take place at a time and location that is convenient to you. An honorarium to acknowledge your time and expertise is offered, as well as a meal should the interview occur over the lunchtime or suppertime. Your participation in this research study is voluntary

If you are interested in learning more about the opportunity to participate in this study, please contact:

Sincerely,

Pamela Wener
Principal Investigator
Telephone: 204-789-3456   Email: Pam.Wener@med.umanitoba.ca

Appendix F: Research Participant Informed Consent Form for Provider Groups- PCPs and Mental Health Care Providers

Principal Investigator: Pamela Wener
R125-771 McDermot Ave.
Department of Occupational Therapy
University of Manitoba
Winnipeg, Manitoba R3E 0T6

Co-Investigators: Dr. Roberta Woodgate
Professor, Faculty of Nursing
465 Helen Glass Centre for Nursing
Faculty of Nursing
University of Manitoba
Telephone: (204) 474-8338

Telephone: (204) 480-1302

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the study staff. You may take your time to make your decision about participating in this study and you may discuss it with your friends or family. This consent form may contain words that you do not understand. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of Study
The purpose of this qualitative study is to increase our understanding of interprofessional team collaboration in primary care. Specifically, this study will focus on the interprofessional collaborations between primary care physicians or nurse practitioners, referred to as the primary care providers (PCP) and psychiatrists or counselors referred to as mental health providers (MHP) in response to client's mental health concerns presented in the primary care setting.

Previous work carried out by the Regional Health Authority (WRHA) Primary Health Care and Shared Mental Health Care programs identified collaboration among health professionals, as one of the key facilitators contributing to the success of the current primary health care/shared mental health care joint service. This study will build on this previous work by focusing on decision making process that occurs by the health care providers when a patient presents with mental health concerns.

The research overall objectives for this study are:
1. To detail health care team members' perspectives and experiences of interprofessional collaboration to deliver mental health services in primary health care settings.
2. To identify how the individual (micro), professional and team (meso), and systemic (macro) conditions and interrelationships influence the interprofessional collaboration process that occurs in the context of shared mental health care.
3. To identify the opportunities and challenges of the interprofessional collaboration process in the context of shared mental health care.

This study will include 3 phases

- <u>Phase 1</u> January 2011-January 2012- Understanding the need for interprofessional collaboration between PCP and mental health care providers
- <u>Phase 2</u> March 2012-January 2013- Exploring team interprofessional collaboration at the micro and meso level
- <u>Phase 3</u> January 2013-January 2014-Exploring the macro level policies and documents that support interprofessional collaboration.

At this time, you are being asked to participate in <u>Phase 2</u> of this study. The objective of Phase 2 is to understand and detail interprofessional collaboration between primary care providers and mental health providers from the *team's* perspective. A total of 50 participants will participate in this study.

<u>Study Procedures:</u>
If you agree to participate in this study the researcher or research assistant will contact you by telephone or email to request your mailing address and to provide any information you may want about the study. If at this time, you indicate that you are interested in participating in this study, this informed consent form will be mailed to you at your worksite. After approximately one week, the research assistant will contact you by telephone or email, to arrange for a focus group interview time and location that is convenient for you and your team. The interview will be conducted by the principal investigator and will be approximately 90 minutes in duration. The interviews will be audio recorded and transcribed verbatim. Once the interviews are transcribed, audio tapes will be destroyed. No identifying information will be on the interview data. All names on the transcripts will be pseudonyms.
If you take part in this study, you will participate in the following: One 90-minute focus group interview at a time and location that is convenient for you. The interview will be audio recorded. The principal investigator will be conducting all interviews. The interview will focus on your team's experiences regarding interprofessional collaboration between primary care and mental health care to meet the needs of your patients with mental health concerns.

You can stop participating in this study at any time. However, if you decide to stop participating we encourage you to talk to the study staff first.

Results from Phase 2 of the study will be sent directly to all participants by email in the form of a report that will reflect the collective results of all 10 focus group interviews rather than individual results.

<u>Risks and Discomforts:</u>
There are no known risks or discomforts of participating in this study.

<u>Benefits:</u>
There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will benefit health care providers working in primary care and mental health care as well as, patients with mental disorders in the future.

<u>Costs:</u>
It is expected that all participants in this study will participate outside of their regular work time.

<u>Payment for Participation:</u>
All participants will be given a $100.00 for participation in the focus group interview as it is anticipated that interviews will occur outside the health care provider's work time. This honorarium is to acknowledge the practitioner's expertise and time taken to participate in this research. Practitioners cannot be available to see patients during the time they are participating in this interview. For practitioners who have a fee-for-service agreement the time spent in the interview may represent a loss of income.

Confidentiality:
Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. Each study participant will receive a pseudonym that will be used on all study information including the Practice Information Form and interview transcripts. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All research information including informed consent forms, completed information forms and interview transcripts will be kept in a locked secure area in the Principal Investigator's office (R125-771 McDermot Ave. or T261B-770 McDermot Ave.) and only the study staff identified will have access to this information. If any of your research records need to be copied to any of the above, your name and all identifying information will be removed. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba

Voluntary Participation/Withdrawl from the Study:
Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from the study will not affect your employment by the WRHA. We will tell you about any new information that may affect your health, welfare, or willingness to stay in this study.

Questions:
You are free to ask any questions that you may have about the study and your rights as a research participant. If any questions come up during or after the study contact Pamela Wener at (204) 789-3456

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all your questions.

<u>Statement of Consent:</u>
I have read this consent form. I have had the opportunity to discuss this research study with Pamela Wener and or his/her study staff. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member) I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board, for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I agree to be contacted for future follow-up in relation to this study?

Yes____   No____

Participant signature _____Date _____
                                                                                                          (day/month/year

Participant Printed Name: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent

Printed Name: _____   Date _____
                                                                                                      (day/month/year)
Signature: _____

Role in the study: _____

Appendix G: Research Participant Informed Consent Form for Program Leaders

Principal Investigator: Pamela Wener
R125-771 McDermot Ave.
Department of Occupational Therapy
University of Manitoba
Winnipeg, Manitoba R3E 0T6

Co-Investigators: Dr. Roberta Woodgate
Professor, Faculty of Nursing
465 Helen Glass Centre for Nursing
Faculty of Nursing
University of Manitoba
Telephone: (204) 474-8338

Telephone: (204) 480-1302

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the study staff. You may take your time to make your decision about participating in this study and you may discuss it with your friends or family. This consent form may contain words that you do not understand. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of Study
The purpose of this qualitative study is to increase our understanding of interprofessional team collaboration in primary care. Specifically, this study will focus on the interprofessional collaborations between primary care physicians or nurse practitioners, referred to as the primary care providers (PCP) and psychiatrists or counselors referred to as mental health providers (MHP) in response to client's mental health concerns presented in the primary care setting.

Previous work carried out by the Regional Health Authority (WRHA) Primary Health Care and Shared Mental Health Care programs identified collaboration among health professionals, as one of the key facilitators contributing to the success of the current primary health care/shared mental health care joint service. This study will build on this previous work by focusing on decision making process that occurs by the health care providers when a patient presents with mental health concerns.

The research overall objectives for this study are:
1. To detail health care team members' perspectives and experiences of interprofessional collaboration to deliver mental health services in primary health care settings.

2. To identify how the individual (micro), professional and team (meso), and systemic (macro) conditions and interrelationships influence the interprofessional collaboration process that occurs in the context of shared mental health care.
3. To identify the opportunities and challenges of the interprofessional collaboration process in the context of shared mental health care.

This study will include 3 phases

- Phase 1 January 2011-January 2012- Understanding the need for interprofessional collaboration between PCP and MHP
- Phase 2 March 2012-April 2013- Exploring team interprofessional collaboration at the micro and meso level
- Phase 3 January 2013-January 2014-Exploring the macro level policies and documents that support interprofessional collaboration.

At this time, you are being asked to participate in Phase 2 of this study. The objective of Phase 2 is to understand and detail interprofessional collaboration between primary care providers and mental health providers from the *Program's* perspective.

Study Procedures:
If you agree to participate in this study the researcher or research assistant will contact you by telephone or email to request your mailing address and to provide any information you may want about the study. If at this time, you indicate that you are interested in participating in this study, this informed consent form will be mailed to you at your worksite. After approximately one week, the research assistant will contact you by telephone or email, to arrange for a focus group interview time and location that is convenient for you and your team. The interview will be conducted by the principal investigator and will be approximately 90 minutes in duration. The interviews will be audio recorded and transcribed verbatim. Once the interviews are transcribed, audio tapes will be destroyed. No identifying information will be on the interview data. All names on the transcripts will be pseudonyms.

If you take part in this study, you will participate in the following: One 90-minute focus group interview at a time and location that is convenient for you. The interview will be audio recorded. The principal investigator will be conducting all interviews. The interview will focus on your team's experiences regarding interprofessional collaboration between primary care and mental health care to meet the needs of your patients with mental health concerns.

You can stop participating in this study at any time. However, if you decide to stop participating we encourage you to talk to the study staff first.

Results from Phase 2 of the study will be sent directly to all participants by email in the form of a report that will reflect the collective results of all focus group interviews rather than individual results.

Risks and Discomforts:
There are no known risks or discomforts of participating in this study.

Benefits:

There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will benefit health care providers working in primary care and mental health care as well as, patients with mental disorders in the future.

Costs:
It is expected that all participants in this study will participate outside of their regular work time.

Payment for Participation:
All participants will be given a $100.00 for participation in the focus group interview as it is anticipated that interviews will occur outside the health care provider's work time. This honorarium is to acknowledge the practitioner's expertise and time taken to participate in this research. Practitioners cannot be available to see patients during the time they are participating in this interview. For practitioners who have a fee-for-service agreement the time spent in the interview may represent a loss of income.

Confidentiality:
Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. Each study participant will receive a pseudonym that will be used on all study information including the Practice Information Form and interview transcripts. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All research information including informed consent forms, completed information forms and interview transcripts will be kept in a locked secure area in the Principal Investigator's office (R125-771 McDermot Ave. or T261B-770 McDermot Ave.) and only the study staff identified will have access to this information. If any of your research records need to be copied to any of the above, your name and all identifying information will be removed. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba

Voluntary Participation/Withdrawl from the Study:
Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from the study will not affect your employment by the WRHA. We will tell you about any new information that may affect your health, welfare, or willingness to stay in this study.

Questions:
You are free to ask any questions that you may have about the study and your rights as a research participant. If any questions come up during or after the study contact Pamela Wener at (204) 789-3456

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all your questions.

Statement of Consent:

I have read this consent form. I have had the opportunity to discuss this research study with Pamela Wener and or his/her study staff. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member) I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board, for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I agree to be contacted for future follow-up in relation to this study?

Yes_____   No_____

Participant signature _____Date
        _____

                                                                (day/month/ye
                                                        ar

Participant Printed Name: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent

Printed Name: _____Date _____
                                                        (day/month/year)

Signature: _____

Role in the study: _____
Version date: March 8, 2013   Page 4 of 4   Initials _____

Appendix H: Practice Information Form for PCPs

<u>Practice Information Form</u>

Research ID _____

Date:_____

1. Please check ( ) the one that best describes your role on the health care team

   o   Nurse Practitioner
   o   Family Physician-Alternate Funded (WRHA)
   o   Family Physician-Fee-for-Service Funded

2. Year of graduation as a nurse practitioner, general practitioner or family practice practitioner?

   _____

3. How long have you worked at the current health care centre?
   o   < 1 year
   o   1-3 years
   o   3-5 years
   o   >5 years

4. Please identify your gender:

   o   Male
   o   Female

5. Please identify your age
   o   25<
   o   25-30
   o   30-40
   o   40-50
   o   50-60
   o   >60

Practice Information Form Phase 1
Version date: January 4, 2011

6. Please identify the number of Years that you have participated in the WRHA Shared Mental Health Care Program

   o < 1 year
   o 1-3 years
   o 3-5 years
   o >5 years

7. Please estimate of how often over the past year you have used the services of the Shared Mental Health Care Psychiatrist?
   o   1-5 times/ year
   o 6-10 times/ year
   o 11-20 times/year
   o > 20 times/ year

   For approximately how many cases?
   o None
   o 1-5
   o 6-10
   o 11-20
   o 21-40
   o >40

8. Estimate of how often over the past year you have used the services of the Shared Mental Health Care Counsellor?

   o 1-5 times/ year
   o 6-10 times/ year
   o 11-20 times/year
   o > 20 times/ year

   For approximately how many cases?
   o None
   o 1-5
   o 6-10
   o 11-20
   o 21-40
   o >40

Practice Information Form Phase 1
Version date: January 4, 2011

Appendix I: Practice Information Form for Health Care Providers and Program Leaders

<u>Health Care Provider Practice Profile</u>

Research ID _____

Date:_____

1.   Please check ( ) the one that best describes your role on the health care team
   - Nurse
   - Nurse Practitioner
   - Family Physician (WRHA funded)
   - Family Physician (Fee-for –service)
   - Psychiatrist
   - Shared Care Counselor
   - Clinical Dietician
   - Primary Care Assistant
   - Clinical Supervisor
   - Site Manager
   - Other (specify)_____

2.   Please identify your professional diploma or degree_____

3.   Year of graduation _____

4.   How many years have you worked as a health care provider?_____

5.   Identify your gender:

   - Male
   - Female

6.   Please identify your age
   - 25<
   - 25-30
   - 30-40
   - 40-50
   - 50-60
   - >60

7.   How long have you worked at the current health care centre or service?
   - < 1 year
   - 1-3 years

- o 3-5 years
- o >5 years

8. Please identify the number of Years that you have participated in the WRHA Shared Mental Health Care Program

HCP Practice Profile Version Date: February 27, 2012

- o < 1 year
- o 1-3 years
- o 3-5 years
- o >5 years

Mental Health Care Providers please go to question 12.

Primary Care Providers Only

9. Please estimate of how often over the past year you have used the services of the Shared Mental Health Care Psychiatrist?
   - o 1-5 times/ year
   - o 6-10 times/ year
   - o 11-20 times/year
   - o > 20 times/ year

   For approximately how many cases?
   - o None
   - o 1-5
   - o 6-10
   - o 11-20
   - o 21-40
   - o >40

10. Estimate of how often over the past year you have used the services of the Shared Mental Health Care Counsellor?

    - o 1-5 times/ year
    - o 6-10 times/ year
    - o 11-20 times/year
    - o > 20 times/ year

11. For approximately how many cases?
    - o None

- o 1-5
- o 6-10
- o 11-20
- o 21-40
- o >40

Mental Health Care Providers Only

Practice Information Form Phase 1
Version Date: February 27, 2012

12. Please estimate of how often over the past year you have provided mental health services (direct and consultation services) to the primary care provider for patients with mental health concerns?
   - o 1-5 times/ year
   - o 6-10 times/ year
   - o 11-20 times/year
   - o > 20 times/ year

13. For approximately how many cases and for what type of service?
   - o None
   - o 1-5   ○Consultation   ○ Direct patient service   ○ Other(specify)
     _____
   - o 6-10   ○Consultation   ○ Direct patient service   ○ Other(specify)
     _____
   - o 11-20   ○Consultation   ○ Direct patient service   ○ Other(specify)
     _____
   - o 21-40   ○ Consultation   ○ Direct patient service   ○ Other(specify)
     _____
   - o >40   ○ Consultation   ○ Direct patient service   ○ Other(specify)
     _____

Appendix J: PCP Interview Guide

1. Can you describe your primary care practice?

   Are the patients you serve mostly males, females? Older/younger?

   What are the most common types of health issues that you see?

   Has your practices changed in the last 5 years and if so how?

The idea of shared care recognized the pivot role that the PHP play in the health care system. Most patients with mental disorders are first and often only, seen by their PHP.

2. Could you tell me about your experiences in your practice of providing health services to patients with mental health problems?

   How often do you need to provide services to MH patients?

   What types of mental health problems do the patients present?

3. Could you tell me about an experience where you were asked by a patient to provide mental health services/support to a patient when you felt comfortable or equipped to do so?

   What was the presenting problem?

   What types of decision need you need to make in this situation?

   In this circumstance what made you feel comfortable or equipped to provide MHP?

4. Could you tell me about an experience where you were asked to provide mental health services/support to a patient when you did not feel comfortable or equipped to do so?

   What was the presenting problem?

   What types of decisions did you need to make in this situation?

   What was it like to feel uncomfortable or ill equipped?

   In this circumstance, what would have made you feel more comfortable or better equipped to provide MHP?

5. Are there certain types of patient for whom you feel better or less equipped to provide service?

6. Since participating in the SMHC program, have you had the opportunity to collaborate with a MHP?

> What was involved in deciding to collaborate with a MHP?

> Who did you collaborate with? Psychiatrist or counselor

> What was the purpose of your collaboration?

7. If you did collaborate with a MHP, please describe to me how you collaborated (met together, letter, email, saw the patient together?)

> MHP saw patient and referred back/sent consultation letter

> MHP and PHP saw patient together? Patient seen by MHP and then PHP and MHP talked?

8. If you did collaborate with a MHP could you tell me about any decisions you made as a results or during this collaboration?

9. Who made these decisions? PHP, MHP or patient or collaboratively?

Appendix K: Health Care Provider Interview Guide

The following interview questions are intended to answer the research questions 2-4.

2. To detail the health care teams' experiences of building interprofessional collaborative relationships within the context of Collaborative Mental Health Care services
3. To identify how the individual (micro), professional and team (meso), and systemic (macro) conditions and interrelationships influence the interprofessional collaboration process that occurs in the context of shared mental health care.
4. To identify the opportunities and challenges of the interprofessional collaboration process in the context of shared mental health care.

Some of you have already participated in individual interviews however, during this group interview we will focus more on how the team works to provide mental health services in primary care. Specifically we will focus on the interprofessional collaboration process that you use to provide mental health services to patients.

1. Who is involved in the interprofessional collaboration process? physicians, nurse practitioners, mental health counselors, psychiatrists, patients, families, others?
2. What kinds of mental health concerns do patients or primary care providers present?
3. How is the interprofessional collaboration initiated?
4. Once the referral to Shared Care is made:
   a. What is the role of the primary care physician/nurse practitioner
   b. What is the role of the shared care counselor/psychiatrist
   c. What is the role of the patient/family/others
   d. Who makes the final decision about the plan of action?
5. How do the roles vary depending on the services requested or required?
6. How are decisions made? What happens if there is disagreement?
7. How are conflicts resolved?
8. How is information communicated between health care providers?
9. What role does the patient play in the interprofessional collaboration process?
10. How are the unique circumstances of a given patient considered in the interprofessional collaboration process?
11. What do you see as your team's strengths?
12. What would make your team better?
13. What does the primary care program or the mental health program have in place that encourages or facilitates collaborative practice?
14. What have been your biggest challenges collaborating ?
15. What could the program or the WRHA do to enhance interprofessional collaboration?

16. What have been the opportunities/strengths of interprofessional collaboration for your shared patients with mental health concerns?

Appendix L: Program Leadership Group Focus Group Guide

The following interview questions are intended to answer aspects of the research questions 2-3.

2. To identify how the systemic (macro) conditions and interrelationships influence the interprofessional collaboration process that occurs in the context of shared mental health care.
3. To identify the organizational barriers and facilitators of the interprofessional collaboration process in the context of shared mental health care.

Some of you may have participated in focus groups however, during this interview we will focus more on the programs, Primary Care and Mental Health and how these support the Shared Care Mental Health Service. Specifically we will focus on the structures and processes that you perceive facilitate or hinder interprofessional collaboration process to deliver mental health services.

1. From your perspective, what is the role of the various team members in delivering mental health care?
2. What do you see as your role in relation to delivery mental health care in primary care settings?
3. Shared care is thought to involve interprofessional collaboration, what does that mean to you?
4. Describe how interprofessional collaboration is used to deliver mental health services in primary care?
5. What structures does the program or the WRHA provide that supports interprofessional collaboration in Shared Care Mental Health? Are there other structures that you think would provide additional support or facilitate greater collaboration?
6. What processes do you think are facilitative of interprofessional collaboration and how does the program or WRHA support these processes? Are there other processes that you think could make a facilitating contribution to interprofessional collaboration?
7. Describe any how the program or WRHA impede interprofessional collaboration? Structures? Processes? What kinds of things could be changed to remove these barriers?
8. What role does this group play in developing and facilitating interprofessional collaboration?
9. What resources does this group access to encourage and support interprofessional collaboration? What kinds of resources are missing/unavailable that could further support interprofessional collaboration?

10. What are your thoughts about the application of Shared Care to other areas of primary care? Pros? Cons? Specific areas?

Appendix M: Newsletter #1, Poster & Updated Newsletter 1 Issue 2

Newsletter 1

Collaboration to Deliver Mental Health Services in Primary Care Settings: Phase 1-Primary Care Provider's Need

Pamela Wener, Ph.D. (Candidate), IIS Program, University of Manitoba
Advisor: Dr. Roberta Woodgate, Ph.D., Professor, Faculty of Nursing, University of Manitoba

Phase 1 Summary Report

Volume 1, Issue 1
May 18, 2012

INTRODUCTION

Implementation of Shared Mental Health Care (SC) program across Canada has increased patient's access to mental health services. Researchers report that collaboration increases timely access to mental health services and are considered best practice. However, lacking is a systematic discovery about the structures and processes that facilitate collaboration in a SC program context.

This summary presents an overview of the results of the first phase of a grounded theory study that explores the working intricacies of collaboration within an SC context and from the perspective of the primary care providers (PCP).

Ethical Approval was received from the University of Manitoba Health Research Ethics Board prior to the beginning of the study.

METHODS

Study Design: A grounded theory design[2] that includes three phases.

Participants: Recruitment flyers were emailed and hand-delivered to 110 primary care providers (PCP), fee-for-service physicians, alternatively funded physicians and nurse practitioners (NP) who participate in a centrally located Canadian regional health authority SC program.

Data Collection Tools: Using maximum variation purposive sampling, PCPs were recruited to participate in the study. Data were collected using a socio-demographic questionnaire and individual in-depth semi-structured interviews.

Data Analysis: Data was analyzed using constant comparison analysis, data collection and analysis occurred simultaneously where codes were compared within and between transcripts.

PARTICIPANTS:

- Sixteen PCPs participated in this study.
- Participants included 6 males and 10 females.
- Participants ranged from 30- was 30-65 years.
- Fee-for-service physicians tended to be older than the other PCPs.
- >50% of FFS physicians have been with SC for less than 1 year to 3 years
- 50% of AF physicians have been with SC either <1 year to 3 years or greater than >5 years.
- Nurse Practitioners have all been with SC between 3 to >5 years.
- >50% of the participants have been at their present clinic for more than 5 years.
- Almost 70% of PCPs consult with psychiatrists between 11->20 times per year.
- Most PCPs consult with Shared Care Counselors >20 times per year.

There were three emergent themes that are discussed below.

Meaningful Occupation
- Valuing long-term relations
- Opportunities to collaborate
- Anything can walk through your door
- A natural next step (NP)

MEANINGFUL OCCUPATIONS is about the reasons the PCPs chose to practice in primary care.

Valuing long-term relations: Both physicians and NP are proud and enjoy being primary care practitioners because of the opportunities to develop long-term meaningful relationships and being able to deliver a continuity of care.

Opportunities to collaborate: PCPs look for opportunities where they can collaborate with others and be part of a team.

I wanted the independence... and I the autonomy piece was, but collaborative was a big component for me. (Participant 11)

Anything can walk through your door:
Participants talked about enjoying the challenge they face each day.

...but once I was in medicine I chose family medicine because of the daily challenge ...the challenge of problem-solving and of constantly having to learn and to teach. (Participant 7)

A natural next step: NPs worked in northern communities or other urban centres where they enjoyed practice autonomy. Becoming an NP was a natural next step.

Mental Health Service Delivery in Primary Care Settings
- My practice ages with me
- The complexity of it all
- It's about a team

MENTAL HEALTH SERVICE DELIVERY IN PRIMARY CARE is about of delivering care in the context of an aging population and how this added complexity requires collaboration.

Its about the context: PCPs describe their practices as *aging with them* where patients are older and have multiple health and the social issues that are affecting the individual's health.

The complexity of it all: PCPs describe the how treatment becomes complex when in addition to multiple physical and social concerns patients have mental health issues.

...she sort of crumbled...she's had ECT and multiple admissions...perhaps bipolar, certainly very severe depression and a personality disorder and physical illnesses as well and so these are people with sort of multisystem pathology who are difficult to treat because there's so many things going wrong in their lives that their depression is almost refractory. (Participant 1)

It takes a team: Collaboration is needed to clarify diagnosis, medications, coping skill development, or when treatment is not progressing as expected. Co-location facilitates mutual trust and respect, role clarification, and knowledge exchange between health care providers. Modes of informal communication develop as a result of co-location and are highly valued by PCPs. Formal communications confirm PCP's own thinking or provides a specific treatment protocol for a patient.

...so she was evaluated and then we had a conversation right at my desk, right after she was evaluated and we talked about what do we think is going on. (Participant 14)

Barriers to collaboration included PCPs who work part-time and their days of work do not coincide with the SC counselor or psychiatrist. This lack of co-location impacts the relationship and results in PCP   t l   erce' ng the service as available.

Patient-Centred Approach
- It's about the person
- Shared decision making
- Laying the groundwork

PATIENT-CENTRED APPROACH is about recognizing patients as individuals and respecting their right to make choices.

It's about the person: PCPs recognize the importance of how they connect and engage with individual patients.

The way you can have a moment with a patient where you actually really have connected on a much deeper level, and how important that can be. (Participant 5)

Shared decision-making: PCPs believe that most health decisions need to be made collaboratively with the patient having the final choice.

The biggest thing is whether the client wants to access the service or not....that's a decision we make together.... (Participant 11)

Laying the ground work: PCPs use a variety of skills such as reframing or leveraging their relationship to increase the patient's readiness for mental health services.

...people come in asking for help... you provide them with suggestions and they're just not at the point where they're ready to follow through, it takes a lot, they need to be ready to start working towards fix-

Figure 1. Model of Collaboration (Preliminary)
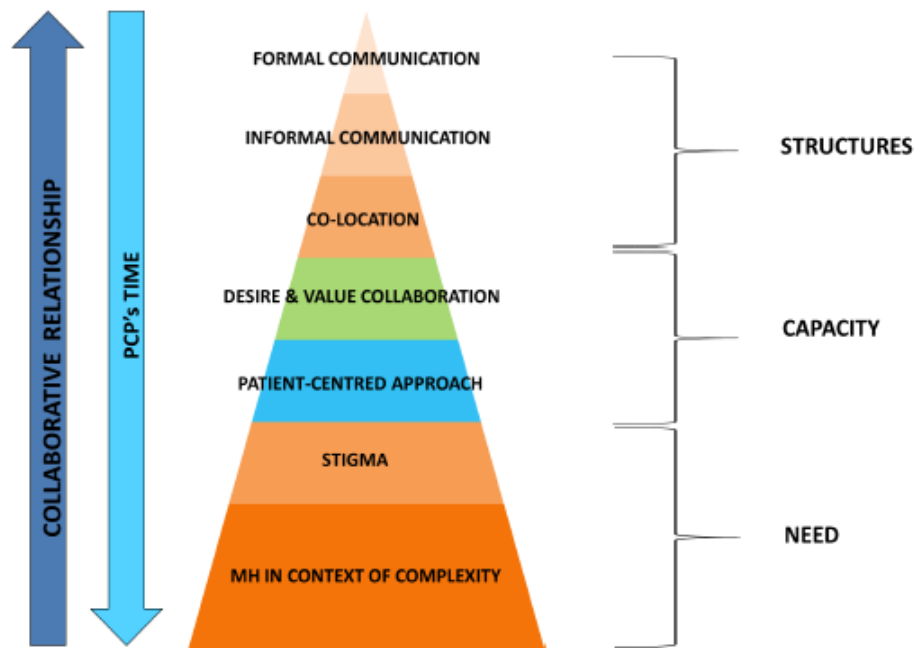
PCPs identify a need to collaborate with Mental Health Care Providers to provide timely services for those patients whose needs are complex. Furthermore, PCPs believe that when mental health services are provided in the PCPs offices patient's perceptions of stigma may be reduced. PCPs hold beliefs that are congruent with collaboration: patient-centred care and the value of collaboration for the purpose of improving patient outcomes. The need for and capacity to collaborate set the stage for establishing structures that facilitate collaboration. Care provider co-location facilitates the establishment of collaborative relationships, based on mutual trust and respect. Co-location lays the foundation for formal and informal modes of communication that ultimately may improve patient care.

For further information or
if you have questions or
comments please contact
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Poster: Wener, Woodgate, Goossen, & Jones (2012)

Primary and Mental Health Care Providers Delivering Mental Health Services in Community Settings: Towards a Model of Collaboration

Pamela Wener*, Ph.D. (Candidate), Roberta Woodgate**, Ph.D, Randolph Goossen***, MD, FRCPC, Teresa Jones,**** MA

* Individual Interdisciplinary Studies, ** Faculty of Nursing, ***Faculty of Medicine, Department of Psychiatry, University of Manitoba, **** WRHA, Shared Mental Health Care Program

INTRODUCTION

Implementation of Shared Mental Health Care (SC) program across Canada has increased patient's access to mental health services. A key component of SC programs is interprofessional collaboration between primary and mental health care providers. Researchers report that this type of intra- and interprofessional collaboration increases timely access to mental health services and are considered best practice. However, lacking is a systematic discovery about the structures and processes that facilitate collaboration in a SC program context.

OBJECTIVES

This poster presents the results of the first phase of a grounded theory study that explores the working intricacies of collaboration within an SC context and from the perspective of the primary care providers.

METHODS

Ethical Approval was received from the University of Manitoba Health Research Ethics Board prior to the beginning of the study.

Study Design: A grounded theory design that includes three phases.

Participants: Recruitment flyers were emailed and hand-delivered to 110 primary care providers (PCP), fee-for-service physicians, alternatively funded physicians and nurse practitioners (NP) who participate in a centrally located Canadian regional health authority SC program.

Data Collection Tools: Using maximum variation purposive sampling, PCPs were recruited to participate in the study. Data were collected using a socio-demographic questionnaire and individual in-depth semi-structured interviews.

Data Analysis: Data was analyzed using constant comparison analysis, data collection and analysis occurred simultaneously where codes were compared within and between transcripts.

FINDINGS

Participants: A total of 16 PCPs, 10 females and 6 males ranging in age from 30-65 years participated in this study.

Position	Yrs. at SC Program			Yrs. at Current Clinic			Total
	<1-3	3-5	>5	<1-3	3-5	>5	
Fee-for-service Physicians	4	1	2	1		6	7
Alternatively-funded Physicians	2		2	2		2	4
Nurse Practitioners		3	2		4	1	5
Total	6	4	6	3	4	9	16

Position	Psychiatrist Use Consultations/year			# of Cases/Yr.					Shared Care Counselor Use/Yr.			# of Cases/Yr.			
	1-5	6-10	11-20	>20	1-5	6-10	11-20	21-40	>40	1-5	6-10	11-20	>20	1-5	6-10	11-20	21-40	>40
Fee-for-service Physicians	1	3	3	1	0	4	2		1			7		1	3	2
Alternatively-funded Physicians			3	1	1	2	1					4		1	3	
Nurse Practitioners	1		2	2	1		2	2			2	3		2	3	
Total	2	3	7	4	1	5	6	3	1			14		4	9	2

MEANINGFUL OCCUPATIONS is about the reasons the PCPs chose to practice in primary care.

Valuing long-term relations: Both physicians and NP are proud and enjoy being primary care practitioners because of the opportunities to develop long-term meaningful relationships and being able to deliver a continuity of care.

Opportunities to collaborate: PCPs look for opportunities where they can collaborate with others and be part of a team.
I wanted the independence... and I the autonomy piece was, but collaborative was a big component for me. (Participant 11)

Anything can walk through your door: Participants talked about enjoying the challenge they face each day.
...but once I was in medicine I chose family medicine because of the daily challenge...the challenge of problem-solving and of constantly having to learn and to teach. (Participant 7)

A natural next step: NPs worked in northern communities or other urban centres where they enjoyed practice autonomy. Becoming an NP was a natural next step.

MENTAL HEALTH SERVICE DELIVERY IN PRIMARY CARE is about of delivering care in the context of an aging population and how this added complexity requires collaboration.

Its about the context: PCPs describe their practices as aging with them where patients are older and have multiple health and the social issues that are affecting the individual's health.

The complexity of it all: PCPs describe the how treatment becomes complex when in addition to multiple physical and social concerns patients have mental health issues.
...the sort of crumbles...she's had ECT and multiple admissions...perhaps bipolar, certainly very severe depression and a personality disorder and physical illnesses as well and so these are people with sort of multisystem pathology who are difficult to treat because there's so many things going wrong in their lives that their depression is almost refractory. (Participant 1)

It takes a team: Collaboration is needed to clarify diagnosis, medications, coping skill development, or when treatment is not progressing as expected. Co-location facilitates mutual trust and respect, role clarification, and knowledge exchange between health care providers. Modes of informal communication develop as a result of co-location and are highly valued by PCPs. Formal communications confirm PCP's own thinking or provides a specific treatment protocol for a patient.
...so she was evaluated and then we had a conversation right at my desk, right after she was evaluated and we talked about what do we think is going on. (Participant 14)

Barriers to collaboration included PCPs who work part-time and their days of work do not coincide with the SC counselor or psychiatrist. This lack of co-location impacts the relationship and results in PCPs not always perceiving the service as available.

PATIENT-CENTRED APPROACH is about recognizing patients as individuals and respecting their right to make choices.

It's about the person: PCPs recognize the importance of how they connect and engage with individual patients.
The way you can have a moment with a patient where you actually really have connected on a much deeper level, and how important that can be. (Participant 5)
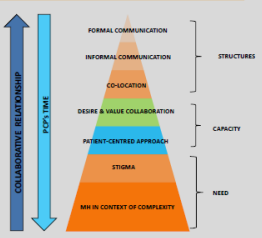
Shared decision-making: PCPs believe that most health decisions need to be made collaboratively with the patient having the final choice.
The biggest thing is whether the client wants to access the service or not....that's a decision we make together... (Participant 11)

Laying the ground work: PCPs use a variety of skills such as reframing or leveraging their relationship to increase the patient's readiness for mental health services.
...people come in asking for help... you provide them with suggestions and they're just not at the point where they're ready to follow through, they'd like a quick fix for the issue but it takes a lot, they need to be ready to start working towards fixing the problems, it's not just a switch that you can turn on and off. (Participant 9)

MODEL OF COLLABORATION (Preliminary)

	STRUCTURES
FORMAL COMMUNICATION	
INFORMAL COMMUNICATION	
CO-LOCATION	
DESIRE & VALUE COLLABORATION	CAPACITY
PATIENT-CENTRED APPROACH	
STIGMA	NEED
MH IN CONTEXT OF COMPLEXITY	

CONCLUSIONS

- PCPs see patients who experience multiple and complex illnesses; these patients benefit from being cared for within a shared care model.
- PCPs use a patient-centred approach to explore the mental health service needs of patients.
- Collaboration between care providers is needed to deliver mental health services in primary care settings.
- Care provider co-location facilitates the establishment of collaborative relationships, based on mutual trust and respect.
- Co-location lays the foundation for formal and informal modes of communication that ultimately may improve patient-care.

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UNIVERSITY OF MANITOBA

Updated Newsletter 1 Issue 2

Collaboration to Deliver Mental Health Services in Primary Care Settings: Phase 1 - Update

Pamela Wener, Ph.D. (Candidate), IIS Program, University of Manitoba
Advisor: Dr. Roberta Woodgate, Ph.D., Professor, Faculty of Nursing, University of Manitoba, CIHR Applied Chair in Reproductive, Child and Youth Health Services and Policy Research

Phase 1 Summary Report

Volume 1, Issue 2 September 6, 2013

INTRODUCTION

Implementation of Shared Mental Health Care (SC) programs across Canada has increased patient access to mental health services. Researchers report that collaboration increases timely access to mental health services and are considered best practice. However, lacking is an exploration about the structures and processes that facilitate interprofessional collaboration (IPC) in a SC program context.

This summary report provides an update on the phase 1 results of this three-phase study that explores the structures and processes that facilitate IPC in a Shared Mental Health Care (SC) program context (Figure 1). Each phase of the study explores the IPC structures and processes from an additional perspective; primary care provider (PCP) (micro), the health care team (meso), and the primary care/shared care regional leadership (macro). That is, phase 1 explores IPC from the PCP's perspective and phase 2 includes results from both the PCP's and the health care team's perspectives.

METHODS

The purpose of phase 1 was to understand PCP's need for IPC with psychiatrists and counsellors to deliver mental health services in primary care settings.
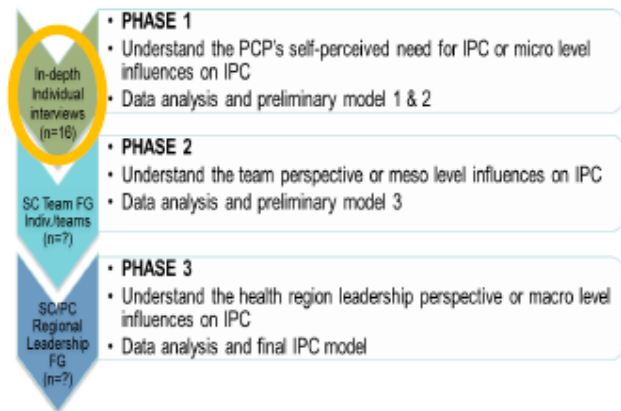
Research questions included:

- *Under what circumstances do PCPs require IPC?*
- *What structures and processes facilitate or hinder IPC?*
- *How do structures and processes facilitate or hinder the IPC process?*

Individual interviews were conducted with PCPs.

Data were analyzed using the constant comparative method, with collection and analysis of data occurring simultaneously. Preliminary results of phase 1 were presented in the first newsletter. This issue presents the final results of this phase (Figure 2).

FIGURE 1: OVERVIEW OF METHODS

In-depth Individual Interviews (n=16)

- PHASE 1
- Understand the PCP's self-perceived need for IPC or micro level influences on IPC
- Data analysis and preliminary model 1 & 2

SC Team FG Indiv./teams (n=?)

- PHASE 2
- Understand the team perspective or meso level influences on IPC
- Data analysis and preliminary model 3

SC/PC Regional Leadership FG (n=?)

- PHASE 3
- Understand the health region leadership perspective or macro level influences on IPC
- Data analysis and final IPC model

RESULTS: Participants

- n=16 PCPs with an age range of 30-65 years.
- >50% of fee-for-service physician participants have been with SC for < 1 year - 3 years.
- 50% of alternatively funded physician participants have been with SC <1 year - 3 years or >5 years.
- Nurse practitioner participants have all been with SC between 3 - >5 years.
- >50% of the participants have been at their present clinic for more than 5 years.
- Almost 70% of PCPs consult with psychiatrists between 11 - >20 times per year.
- Most PCPs consult with Shared Care Counselors >20 times per year.

Need to Collaborate: Preliminary Model 2 (Micro)

FIGURE 2
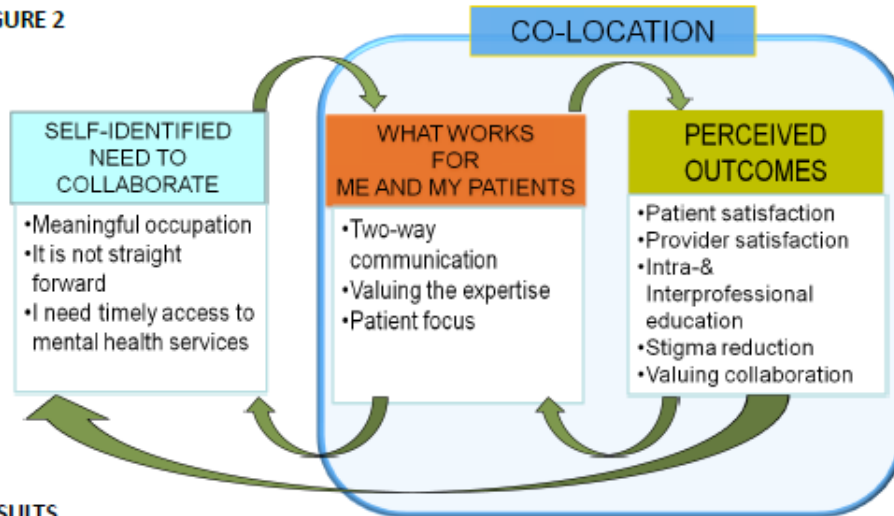
©Pamela Wener, 2013

RESULTS

Data analysis revealed three emergent categories and several subcategories.

1. Self-identified need to collaborate relates to PCPs need for collaboration with a mental health provider (MHP) and includes three subcategories:

Meaningful occupation refers to the reasons why PCPs chose to work in primary care settings. Participants highlighted the opportunity to develop long-term relationships, to deliver continuity of care, being part of a team, and taking on new challenges.

It is not straight forward reflects that PCPs' need to collaborate with MHPs increases with the complexity of patient care (e.g. multiple co-morbidities and medications).

Timely access describes PCPs' need to access mental health services in close proximity of time to when the patients require services.

2. Whatever works speaks to how services must fulfill the needs of both patients and PCPs and includes three subcategories:

Two-way communication captures PCPs appreciation of dialoguing with MHPs about the patient and how co-location allows for enhanced two-way communication.

Valuing Expertise by providers is mutual. PCPs value MHPs specialized knowledge and MHPs value PCPs unique knowledge of the patient and long term relationship.

Patient Focus is maintained as the primary purpose by all providers. This offered positive outcomes to both patients and providers.

3. Perceived outcomes reflects the PCPs expressed belief that the collaborative process between PCPs and MHPs has resulted in increased patient and provider satisfaction, opportunities for intra-and inter-professional education, stigma reduction, and valuing of collaboration.

The Context of Co-location sets the stage for these emergent categories. With each successive collaboration, the needs increased (i.e. the number of consultations), and the stronger the communication and valuing of patient focus became. This feedback loop is represented by arrows in the above schematic.

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Appendix N: Newsletter #2

Collaboration to Deliver Mental Health Services in Primary Care Settings: Phase 2: Team Perspective

Pamela Wener, Ph.D. (Candidate), IIS Program, University of Manitoba
Advisor: Dr. Roberta Woodgate, Ph.D., Professor, Faculty of Nursing, University of Manitoba, CIHR Applied Chair in Reproductive, Child and Youth Health Services and Policy Research

Phase 2 Summary Report

INTRODUCTION

Implementation of Shared Mental Health Care (SC) programs across Canada has increased patient access to mental health services. Researchers report that collaboration increases timely access to mental health services and are considered best practice. However, lacking is an exploration of the structures and processes that facilitate interprofessional collaboration (IPC) in a SC program context.

This summary report presents the results of phase 2 of a three-part grounded theory study that explores the structures and processes that facilitate IPC in a Shared Mental Health Care (SC) program context (Figure 1).

Each phase of the study explores the IPC structures and processes from an additional perspective; primary care provider (PCP) (micro), the health care team (meso), and the primary care/shared care regional leadership (macro). That is, phase 1 explores IPC from the PCP's perspective and phase 2 includes results from both the PCP's and the health care team's perspectives.
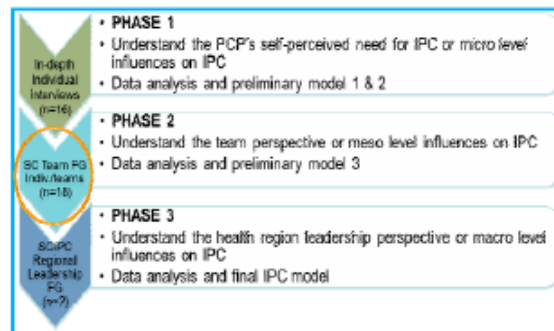
METHODS

The purpose of phase 2 was to understand the team perspective, or meso - level influences on interprofessional collaboration (IPC).

Research questions included:
- *How do team members collaborate to deliver mental health services in primary care?*
- *What structures and processes facilitate or hinder IPC?*
- *How do the structures and processes facilitate or hinder the IPC process?*

Six focus groups were conducted. Data were analyzed using the constant comparison method with analysis and collection occurring simultaneously. Analysis included data from phases 1 and 2 and resulted in a preliminary model of IPC.

FIGURE 1: OVERVIEW OF METHODS

- **PHASE 1**
- Understand the PCP's self-perceived need for IPC or micro level influences on IPC
- Data analysis and preliminary model 1 & 2

- **PHASE 2**
- Understand the team perspective or meso level influences on IPC
- Data analysis and preliminary model 3

- **PHASE 3**
- Understand the health region leadership perspective or macro level influences on IPC
- Data analysis and final IPC model

Participants: n=18 health care team members participated in phase 2 of this study including physicians, (n=10), nurse practitioners (n=3), and shared care counsellors (n=5). Participants included 5 males and 13 females, ranging from 30 to > 60 years of age.

FIGURE 2: OVERVIEW OF RESULTS


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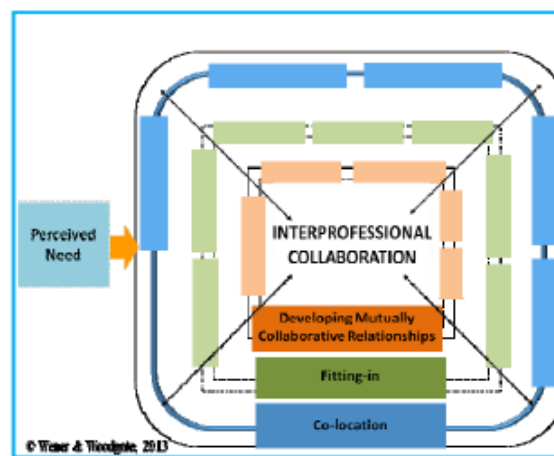
RESULTS

The emergent core category, inter- and intraprofessional patient-focused communication describes the collaboration that takes place when there is a perceived need. It occurs within and between health care providers of the same and different professions within a patient-focused context, where verbal and non verbal communication are both foundational to, and the expression of, this collaborative process.

Four emergent categories expand on this core category: 1. Recognized Need for Collaboration, 2. Co-location, 3. Fitting-in, and 4. Developing Mutually Collaborative Relationships. Category 1, Recognized Need for Collaboration, was described in detail in Volume 1, Issue 2 of this newsletter. The three remaining categories are outlined below. A complete rendering of the preliminary model of collaboration is provided on page 4 of this report.

Co-location

FIGURE
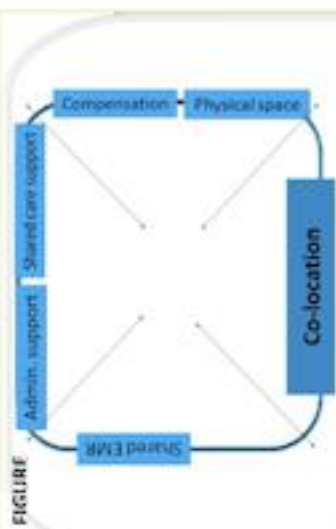
Co-location provides important structures that set the stage for collaboration including physical space, compensation, SC support, administrative support, and shared electronic medical record. All providers who participated in this study strongly supported the need for co-location of providers. One participant describes the importance of co-location:

"Well I think we've defined it in our own way. I mean it could be, it could be anything, uh, that has people working together in many ways. The simplistic sort of plan. But I think we've defined it in a particular way here that we have the counsellors, psychologist, come to our clinic. And then engaging that sort of vocation. So, um, specifically I think it's how we do it that's important. So we do, you know rely on [the office manager] to organise my, my schedule, uh who is already in contact with the primary care physicians who, who need some help in assisting certain things. Even like yesterday, I found out that I was seeing a patient that I didn't need to see and the shared care counsellor was helpful to, uh, you know, cancel that and rebook for. So it's all good. We work in a clinic in a setting which, if I was just in my office somewhere it would be like a whole different story. So there's the co-location again I keep pushin important." FG2

Fitting-in

FIGUR
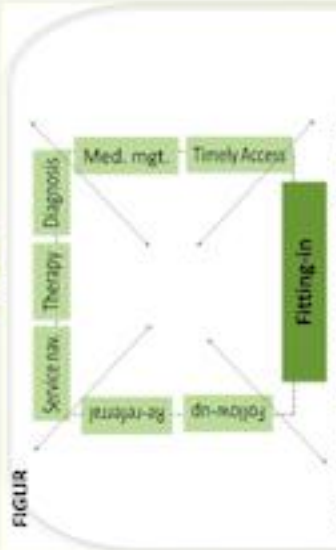
Moving deeper in the model is the process of fitting-in. A key approach of SC is to meet the PCP's need for mental health consultation thereby meeting patients' needs. Participants discussed engaging in a process of "fitting in" to the practice setting and how this took time. There were several processes that SC providers and PCPs engaged in that considered the different practice settings including providing timely access, medication management, diagnosis, short term therapy, service navigation, flexibility surrounding re-referral, and follow-up. One participant described the need to understand the differences between clinic:

"From my experience, it's, you'll probably agree with me on this, it's been learning, understanding and respecting the clinic culture because everybody works differently. So it's really about respecting the clinic you're working in and it's really about having, having a respect and having an understanding of the individual goals of the people that you work with. And so it's not just coming into the clinic and saying, you know, I'm going to do this and I'm going to do that and I don't care about this. I don't care about that. And I don't care about scheduling. It's not about that. It's about, it's about just a lot of it is understanding the clinic culture because every clinic, every doctor is, works differently." FG3

Developing Mutually Collaborative Relationships
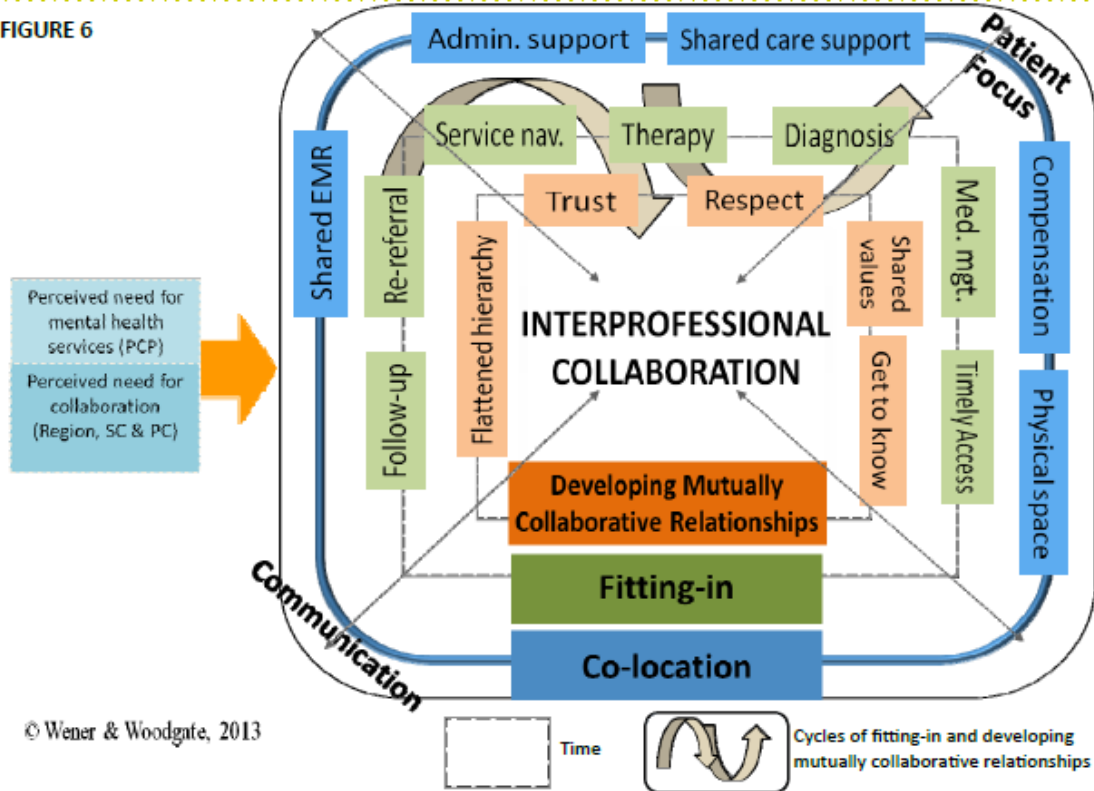
FIGUR

Moving inward again, is the category of developing mutually collaborative relationships. This includes the processes providers engaged in to develop and maintain mutually collaborative relationships whereby the providers worked together to meet the patient's needs. Processes identified by the participants that facilitate the collaborative relationship include getting to know each other, discovering shared values, respect, trust, and a flattened hierarchy. Providers recognized the time it takes to develop and maintain relationships that are reciprocal. One participant described:

"I think as far as trust and respect go, it's, um, if people are deserving of your trust and respect, you don't learn that being separated from them. And so it, and so, um, you certainly find out who people are when you work with them and get to know how they work and how they treat people...It's really hard to have a bad relationships when you know people really well." FG1

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Model of Collaboration

FIGURE 6

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Phase 1 and phase 2 of this study explored the need for collaboration from the micro, or primary care provider's perspective, and meso, or the healthcare team's perspective. The model of IPC is graphically depicted in Figure 6. As shown in the figure, a recognized need for interprofessional collaboration is an essential ingredient. Focusing on the patient as well as open and ongoing communication between health care providers are essential to interprofessional collaboration and these two features underpin and form part of the context in which collaboration takes place.

Participants in this study perceived that the health region provided the structure of Co-location and supported the processes of Fitting-in and Developing Mutually Collaborative Relationships. IPC develops over time and includes a period of fitting-in followed by an investment in developing and maintaining mutually collaborative relationships. Ongoing IPC includes both the processes of *fitting-in* and *developing mutually collaborative relationships*. The health care providers engage with one another using the facilitative structures and processes in a flexible manner, building collaborative relationships in a variety of settings and with a variety of providers.

NEXT STEPS Phase 3 will examine macro level influences on IPC, or the health region leadership perspective. A final model of IPC will then be developed on the basis of these findings.

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