Patient involvement in Interprofessional Collaboration, a catalyst to the delivery of patient-centered care at community-based mental health settings

By

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Abstract

Rationale: The purpose of this study was to examine the patient-lived experience and their role with interprofessional teams.

Methods: This case study used a mixed method approach that was focused on the views of patients with mental illness (12) and healthcare and social care professionals (11) at a mental health unit in a Canadian community hospital. Data collection included contextual observations of interprofessional team meetings, a questionnaire completed by professionals, and individual interviews with professionals and patients.

Results: Shortage of social workers, low interprofessional team diversity, and a lack of patient education created negative patient experiences and delays in patient discharge plans. Improving patient satisfaction and adherence to treatment plans were associated with developing patient decision-support aids and including a diverse group of professionals and community partners.

Conclusions: Shared decision-making is a fundamental component of patient-centered care, and encourages patients to take responsibility of their own mental health needs.

Key Words: Interprofessional, collaboration, patient involvement, mental illness, patient-centered care.

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Glossary of Terms

Interprofessional care: The provision of comprehensive health service to patients by multiple healthcare professionals who work collaboratively to deliver quality care within and across settings (Health Force Ontario [HFO], 2010).

Interprofessional collaboration (IPC): When a group of professionals representing particular disciplines with different values and experiences work together as a team to provide healthcare service delivery (Kilfoil, 2007).

Interprofessional Education (IPE): It is the process by which two or more health professions learn with, from, and about each other across the spectrum of their life-long professional/educational journey, to improve collaboration, practice, and quality of patient-centered care (HFO, 2010).

Interprofessional (IP) Team: Multiple health and social care providers that work together as a team to provide healthcare service delivery (Margison, 2009).

Interprofessional team meetings (IP meetings): Daily meetings held at the Mental Health Unit with the IP team to discuss patient discharge and treatment plans on a case-by-case basis.

Key Informants: Professionals selected for interviews based on highest degree of participation and contribution to the decision-making process during IP team meetings at the Mental Health Unit.

Methodological Triangulation: The use of more than one research method (e.g., interviews and observations) to gather data to compensate for individual limitations and exploit the respective benefits of each method (Shenton, 2004).

National Interprofessional Competency Framework (NICF): This framework serves as a guide to six competency domains that were developed based on the experience of healthcare professionals and their practice context to achieve effective IPC. The domains include: patient/client/family/community-centered care, role clarification, team functioning, collaborative leadership, and interprofessional conflict resolution (CIHC, 2010).

Patient-Centered Care (PCC): Care that requires practitioners to integrate and value the engagement of patients, their families and the community as partners in designing and implementing care/services (Canadian Interprofessional Health Collaborative [CIHC], 2010).

CHAPTER 1

Introduction

1.1 Statement of the Problem

The Biopsychosocial Model was championed in the mid-20th century in an effort to reverse the dehumanization of medicine and disempowerment of patients by the prevailing biomedical model (Borrell-Carrió, Suchman, & Epstein, 2004). The Biopsychosocial Model is a holistic approach which focusses on the patient subjective experiences in order to understand the patient's suffering and the biological, psychological, and social dimensions of their illness (Borrell-Carrió et al., 2004). Unfortunately, the clinical applications of this Model remain unsuccessful and resources to treat and prevent mental illness remain insufficient in Canada and all over the world (World Health Organization [WHO], 2011).

Mental illnesses are recognized as a serious and growing problem in Canada, such that the Canadian Mental Health Association [CMHA] (2014) estimated that 20% of Canadians experience a mental illness at some point in their lives. Mental illness includes mood disorders, anxiety, eating disorders, Attention Deficit Disorder, schizophrenia, psychosis, and suicide. It affects all Canadians either directly or indirectly through a family member, friend or colleague (CMHA). In 2014, CMHA reported that teenagers and young adults aged 15-24 experience the highest incidence of mental illness of any age group in Canada. The economic cost of mental illnesses in Canada for the healthcare system was estimated to be at least $7.9 billion in 1998 – $4.7 billion in care, and $3.2

billion in disability and early death (CMHA). The stagnancy in progress with reducing the effect of mental illness on Canadians is alarming, especially when there still remains few data and limited guidance about how to implement Interprofessional Collaboration (IPC) in the delivery of decision support to patients with mental illness (Campbell, Stowe, & Ozanne, 2011). IPC is a process that includes a group of professionals from particular disciplines and experiences, working together to deliver healthcare services (Kilfoil, 2007). In 2010, Health Force Ontario (HFO) defined IPC as the provision of comprehensive health service to patients by multiple healthcare professionals who work collaboratively to deliver quality care within and across settings. Although IPC is increasingly linked to patient-centred care, the role of patients in the collaborative process is not clear in the mental health literature to date. Hence to address the role of the patient within interprofessional (IP) teams, the objectives of this case study using a mixed-methods approach were:

I. To document the patient-lived experience from the perspective of patients with mental illness.

II. To determine the extent to which patients with mental illness are involved in planning their care.

III. To identify approaches by which IPC can facilitate patient-centered practice and support the decision-making process with patients in mental health settings.

This case-study used a mixed methods approach to gather data. The purposive sample included healthcare and social care professionals, and patients at a Mental Health Unit situated in an Ontario community hospital.

1.2 Background

The Canadian Institute for Health Information (CIHI) reported that the national healthcare expenditure by provincial and territorial governments in Canada was $183.9 billion in 2009 (CIHI, 2011). However, the Conference Board of Canada, WHO, and the Commonwealth Fund have all rated Canada's healthcare system poorly in terms of value for money and efficiency (Canadian Medical Association [CMA], 2010). Surveys have repeatedly shown the Canadian healthcare system is not as well managed as it must be, resulting in the rise of issues such as the lack of timely access to see Family Physicians, an increasing lack of access to specialists and specialized treatment (CMA, 2010). End of life issues are also becoming increasingly important with the rise of the Canadian aging populations many of which don't have access to expert palliative care (CMA). Moreover, diabetes is recognized in Canada as a prevalent chronic disease, and the Ministry Of Health and Long Term Care (MOHLTC) announced in July 2008 a comprehensive approach to preventing, managing, and treating diabetes includes improving service by the increased adoption of clinical practice guidelines by interprofessional (IP) teams (HFO, 2010). In 2008, it was reported that 70% of the consultations with Family Physicians in Canada include psychological problems (Grenier, Chomienne, Gaboury, Ritchie & Hogg, 2008). Therefore in healthcare settings, registered nurses, family physicians and other allied health professionals have been encouraged to work together to improve healthcare access, patient satisfaction, and optimize healthcare (Enhancing Interdisciplinary Collaboration in Primary Healthcare, 2005). Also, the Romanow and Kirby Reports on the future of healthcare in Canada recommended that mental healthcare needed to be community-based and accessible (Grenier et al., 2008). IPC has therefore

been increasingly considered in healthcare as it is believed to provide patient-centered and high quality care. This collaborative process also hopes to improve the care of seniors through timely access to necessary health services and community supports, better coordination between specialized seniors' service professionals, and improve access and support around wellness, self-management, and prevention (Margison, 2009). Interprofessional Education (IPE) for collaborative patient-centered practice has also been adapted to improve collaboration, practice, and quality of patient-centered care (Ateah et al., 2010). IPE is defined as the process by which two or more health professions learn with, from, and about each other across the spectrum of their life-long professional/educational journey (HFO, 2010).

IPC is not a new concept in the literature and over the years has been recognized more in the world of academia as an effective approach to improved healthcare delivery. Since 1987, the Centre for the Advancement of Interprofessional Education (CAIPE) has been internationally recognized and designed specifically for the advancement of IPC and IPE, and has been promoting and developing IPE through its members in the United Kingdom and elsewhere (HFO, 2010). To address the issue of ensuring the long term sustainability of the health-care system, federal, provincial, and territorial governments conducted a number of inquiries and commissions. These included the Romanow Commission in 2002 which focussed on the Future of Healthcare in Canada, and stressed the importance of interprofessional education for patient-centered care in Canada by highlighting the need for new models of health-care education and training (Margison, 2009). In Ontario, the Family Health Teams (FHTs) initiative was formed by physicians, registered nurses, nurse practitioners and other healthcare professionals to help improve

healthcare outcomes by focusing on disease prevention and healthcare promotion. In 2006, HFO was formed by the MOHLTC as the interprofessional care strategic implementation committee that is funded by the Government of Ontario. Their focus is on the implementation of IPC and introducing new and expanded provider roles to increase the number of caregivers working in healthcare and build the skills of those already in the system (HFO). Supporting the HFO Strategy in 2009, the government introduced Bill 179, the *Regulated Health Professions Statute Law Amendment Act*, in attempt to improve access to healthcare in Ontario and make team-based care a key component of health college quality-assurance programs to ensure the ongoing competence of registered health professionals (HFO). Additionally in 2009, the Canadian Interprofessional Health Collaborative (CIHC) was formed by a group of Canadian health organizations, health educators, researchers, health professionals, and students to promote collaboration in health and education (CIHC, 2014). CIHC was funded by Health Canada, and shifted its focus to driving IPC beyond academic institutions, to revitalize the working lives of practising healthcare professionals, and directly affect patient care (HFO).

1.3 Significance and Research Questions

IPC has been reported to promote use of clinical resources, increase efficiency and coordination, reduce tension and conflicts amongst caregivers, and reduce rates of staff turnovers, (Barrett, Curran, Glynn, & Godwin, 2007; Curran, Sharpe, & Forristall, 2007; HFO, 2010; Interprofessional Care Strategic Implementation Committee (ICSIC), 2010). Ateah et al. (2010) confirms interprofessional interventions increase healthcare

professionals' satisfaction as a result of reduced workloads after adding nurse practitioners to the staff mix of registered nurses and physicians in an emergency department. The interprofessional collaboration approach to healthcare has been found to reduce errors and healthcare associated costs, improve quality of care and patient outcomes, as well as increase job satisfaction and retention (HFO, 2010). As IPC is associated with improved quality of care and patient outcomes, failure to implement this collaborative approach may result in delivering sub-optimal care to patients (HFO). Therefore, IPC must be implemented to help improve the patient experience as well as increase the health provider's satisfaction while working within a collaborative setting (HFO).

As previously noted in section 1.1 (Statement of the Problem), mental illness has negatively impacted both the health and economy of Canadians. IPC has then become increasingly linked to patient-centered practice. Active involvement by patients in their recovery process showed significant improvements in clinical outcomes for patients with depression (Campbell, Stowe, & Ozanne, 2011). However, the role of the patient in this collaborative process remains unclear in the mental health literature (Campebell et al., 2011). Therefore, the purpose of this study is to examine the patient-centered experience and the role of the patient with interprofessional teams within a collaborative inpatient mental health setting. It is essential to note that IPC does not only include healthcare professionals, but also social care professionals such as social workers and community partners who work together to ultimately maximize the strengths and skills of health workers, and manage crises and chronic conditions. Therefore, this study also identifies

benefits and challenges of this patient-centered approach from the perspective of patients, as well as healthcare and social care professionals.

The research questions investigated were:

I. How does Interprofessional Collaboration support patient-centered care at community-based mental health settings?

II. To what extent is the patient involved in the IP team?

1.4 Methodology

This case study design uses a mixed method approach with survey, observational and interview data. It takes place at the acute setting of a Mental Health Unit at a large Canadian community hospital in Ontario. IPC has already been incorporated into the hospital's mental healthcare programs. Inpatients have an average stay of seven to twelve days, and are then discharged upon stabilization to continue their treatment in the appropriate setting such as their own homes, nursing homes, emergency community housing, tertiary facilities, and addiction counselling for detox and/or case management.

1.5 Overview of the Study and Framework

The following overview is provided to outline the remaining chapters addressing the research questions stated above.

Chapter Two is a detailed review of the existing literature on IPC and the significance of patient involvement within the field of mental health. It specifically focusses on the integration and perceptions of IPC as well as relationships between

professionals. This chapter also reviews barriers and facilitators to implementing interprofessional practice within health settings.

Chapter Three discusses the methodological approaches, the data sources and techniques used to analyze the data. Similar to other research, this study is subject to limitations which are also described in this chapter along with methods used to validate the findings.

Chapter Four examines in detail all findings produced from the interviews with healthcare and social care professionals, and patients, as well as the results from the survey distributed to the professionals.

Chapter Five provides a discussion of the findings in relation to the National Interprofessional Competency Framework (NICF) which guided the analysis for this study. NICF was proposed by the Canadian Interprofessional Health Collaborative (CIHC) in 2010 as a guide to six competencies required for achieving effective IPC. The domains include: patient/client/family/community-centred care, role clarification, team functioning, collaborative leadership, and interprofessional conflict resolution. These domains were developed based on the experience of healthcare professionals and their practice context (CIHC, 2010).

The thesis is concluded with Chapter Six providing implications of study findings. It also presents lessons learned and suggestions for improving IP practice in the mental health setting. Finally, this chapter summarizes the subsequent contributions of

this study to implementing interprofessional practice and some suggestions for future research.

CHAPTER 2

Literature Review

A literature review was carried out to address the research questions using the standard electronic databases Pro-Quest and Medline, and PsychInfo. Key words used were as follows: patient and involvement and interprofessional and care and mental "health or illness". The search was conducted for the years of 2005-2014, and further supplemented with current knowledge from grey literature sources including Health Canada, Canadian Medical Association (CMA), Health Force Ontario (HFO), and the World Health Organization (WHO). Reference lists of relevant articles were also hand searched. Inclusion criteria consisted of peer-reviewed articles in English, from Evidence-based Medical Resources and Scholarly Journals, under the subject of "Health and Medicine", and for the years of 2005-2014. Exclusion criteria consisted of letters to the editor, interviews, newsletters, debates, conference proceedings, non-peer-reviewed, and non-English literature.

Abstracts of the 184 articles produced were scanned to narrow down the results to 30 literature sources based on six selected themes. These themes were identified in previous literature as detrimental factors to the delivery of effective IPC and patient centered practice. They included: integration of IPC, perceptions of IPC, unequal power relationships within professions, facilitators and challenges encountered, and lastly evidence of patient involvement in the IPC process.

2.1 Sample Characteristics

From the 30 studies selected for this literature review, two studies were conducted in the United Kingdom, one in Australia, one in Sweden, and one in Ireland. Three of the studies were conducted in an international context; five studies were carried out in the United States, while seventeen studies took place in Canada.

Six literature sources included representative random samples of healthcare personnel and professional students who were native to the nation within which the research was conducted (Atwal & Caldwell, 2005; CIHC, 2010; Curran, Sharpe, & Foristall, 2007; Thomas, 2008; Watts, Pierson & Gardner, 2006; WHO, 2011). One Canadian study used the snowballing sampling technique and initially surveyed informants from various professions across federal, provincial and territorial governments, healthcare and educational sectors in Canada (Barker, Bosco & Oandasan, Canada, 2005). The remaining studies were conducted using purposive samples of professional groups including occupational therapists, registered nurses, physicians, psychiatrists, and psychologists.

Only the two studies by Kilfoil (2007) and Coulter and Salhani (2009) included more diverse teams of professionals for their studies, consisting of guidance counsellors, youth workers, social workers, police officers, family physician, community health nurses, mental health counsellors, occupational therapists, and nurse practitioners. The remainder of the studies on IPC and IPE, also the majority of the studies reviewed, focused on the communication between physicians and registered nurses. Very little has been reported on other healthcare workers (e.g. social workers, occupational therapists,

etc.). It is important to ensure this group diversity when investigating the perceptions, facilitators and challenges encountered in the practice of IPC, as they also deliver services that impact patient outcomes (Watts, Pierson & Gardner, 2006). Many have expert knowledge about community resources, which are important to illness prevention, treatment and discharge proceeds of patients (Watts et al., 2006). IP team diversity has shown to facilitate the delivery of comprehensive services to patients in their own communities, thereby creating a convenient and comfortable patient-centered experience (Kilfoil, 2007).

2.2 Study Designs

Most of the literature on the topic of IPC and IPE is based on qualitative methodology. As stated by Barker et al. (2005), qualitative research is a means of exploration which can inform future research, including investigation about whether the factors identified by the participants in the study are applicable to other populations and in other professional settings. Barker et al. recommends that future research incorporates a larger scale mixed methodology exploration of the identified barriers and facilitators to IPC care, in order to achieve optimal results in the interprofessional field of patient-centred care. The combination of quantitative study designs as well as qualitative methods could shed more light on the relationship of the variables in question to the success of IPC and IPE initiatives (Barker et al., 2005).

Six studies used a quantitative study design (Ateah et al., 2010, Haverkamp, Robertson, Cairns, & Bedi, 2011; HFO, 2010; Mitchell, Parker, & Giles, 2011; Poochikian-Sarkissian, 2008; Thomas, 2008; Watts, Pierson & Gardner, 2006). Three

studies adapted a mixed methodology (Kilfoil, 2007; Margison, 2009; Schroder et al., 2011). Barker, Bosco and Oandasan (2005) used a grounded theory design to study factors associated with IPE and IPC practice initiatives, as well as web-based surveys and key informant interviews. NVivo was used for data analysis. Ateah et al. (2010) used a quantitative experimental design with focussed group sessions and a five-point Likert scale questionnaire in order to identify the students' perspectives of health professional collaboration. Similarly, Mitchell et al. (2011) used a questionnaire, with a seven-point Likert scale, to study professional diversity, team identity, threat to professional identity, interprofessional openness, and team effectiveness.

To gain a more in-depth understanding of the challenges and successes of implementing IPC initiatives, in-depth interviews were conducted in eleven of the 30 studies (Barker, Bosco & Oandasan, 2005; Coulter & Salhani, 2009; Kilfoil, 2007; Haverkamp, Robertson, Cairns, & Bedi, 2011; HFO, 2010; Kvarnstrom, 2008; Mann et al., 2009; Reeves et Al., 2009; Shaw, 2008; Piquette, Reeves, & Leblanc, 2009; Schroder et al., 2011). Interviewing is an ideal method to collect data on the experiences of participants during various stages of the research process, and semi-structured interviews benefit the interviewer by ensuring all question areas are covered using a written guide, while still allowing the participants to talk freely while allowing the researchers to collect more data (Barker et al., 2005).

Moreover, ten studies collected data using questionnaires that enabled researchers to articulate their questions and variables of interest, and maintain a higher response rate especially when sample size could be limited due to time constraints and limited

resources (Ateah et al., 2010; Barker et al., 2005; Coleman, Roberts, Wulff, Van Zyl, & Newton, 2008; Curran, Sharpe, & Foristall, 2007; Mitchell, Parker, & Giles, 2011; Kvarnstrom, 2008; Poochikian-Sarkissian et al., 2008; Schroder et al., 2011; Watts, Pierson & Gardner, 2006; WHO, 2011). Mitchell et al. (2011) also stated that a higher response rate could be achieved when participants feel comfortable to provide their honest opinions about IPC while allowing them to remain anonymous.

2.3 Selection of Questionnaire

The ten questionnaires found in the literature review were compared using the six themes identified by the National Interprofessional Competency Framework (NICF) as competency domains necessary for facilitating effective IPC (Table 2-1). These domains were chosen because they fit the objectives of the study, which were to identify the role of the patient with IP teams, and how IPC affected the decision-making process between patients and IP team professionals. The domains were numbered in the comparison found in Table 2-1 below as the following: (1) patient-centered care, (2) communication, (3) conflict resolution, (4) collaborative leadership, (5) team functioning, and (6) role clarification. The questionnaires were reviewed for items addressing each of these competency domains to assist with finding the questionnaires that covered all domains including items on patient-centered care, patient involvement and patient communication with the IP team which are specific in the objectives of this study. Y indicated that the questionnaire item covered the domain while N indicated that the questionnaire items did not cover the domain (Table 2-1).

Table 2-1: Comparison of Questionnaires from the Literature Review

Questionnaire by Author (s)	1	2	3	4	5	6
Pulse Survey by Poochikian-Sarkissian et al. (2008)	Y	N	N	Y	Y	Y
Questionnaire by Coleman et al. (2008)	N	Y	Y	Y	Y	Y
CPAT by Schroder et al.(2011)	Y	Y	Y	Y	Y	Y
Stereotypes Rating Questionnaire by Ateah et al. (2011)	N	N	N	Y	Y	N
Thylefors Survey in Kvarnstrom (2008)	N	Y	N	Y	Y	Y
Questionnaire by Mitchell et al. (2011)	N	Y	N	N	Y	N
Web-based Survey by Barker et al. (2005)	N	Y	N	Y	Y	N
International Survey by WHO (2011)	N	N	N	N	N	N
Questionnaire by Watts et al. (2006)	N	Y	Y	N	Y	N
Questionnaire by Curran et al. (2007)	N	N	N	N	Y	N

The questionnaire by Poochikian-Sarkissian et al. (2008) included items measuring shared-responsibility and team leadership between members of the IP team, but focussed primarily on organizational factors which were not considered for this study. The study by Coleman, Roberts, Wulff, Van Zyl, and Newton (2008) used a questionnaire that assessed attitudes towards an IP learning program, conflict resolution, and of power dynamics in the decision-making process. The Student Stereotypes Rating Questionnaire (SSRQ) by Ateah et al. (2008) rated healthcare professionals on nine characteristics to measure their perceptions and understanding of their own and other health professions, however did not include items on patient-centered care or patient involvement. Kvarnstrom (2008) used a questionnaire which covered the dimensions of

role specialisation, task interdependency, coordination, task specialization, leadership, and role interdependency. Mitchell, Parker and Giles (2011) used a seven-point Likert scale questionnaire to study the relationship between team identity and team diversity with the performance of IP teams. A web-based survey was used by Barker, Bosco, and Oandasan (2005) to describe lived-experience of professionals who successfully and unsuccessfully implemented IPC/IPE initiatives, and to understand factors that affect implementation and sustainability of these initiatives. Additionally, the study by the World Health Organization (2011) used a questionnaire to collect and disseminate information on mental healthcare resources, policies, and budget allocation for mental healthcare in different countries. Watts, Pierson, and Gardner (2006) used a questionnaire that was designed to identify factors contributing to difficulties in implementing discharge plans. The questionnaire by Curran, Sharpe, and Foristall (2007) was designed to measure attitudes towards IPE, IP teams and IP learning in academic settings. Finally, the Collaborative Practice Assessment Test (CPAT) by Schroder et al. (2011) was the only questionnaire that covered all six domains of the NICF model, and thus was selected as means of data collection for this study.

The CPAT measured collaborative practice with interprofessional (IP) team members as well as the level of patient involvement in a team's practice (Schroder et al., 2011). The purpose of the CPAT matched the objective of this study in identifying the role of patients with IP teams in the Mental Health Unit. Also, the CPAT was designed to enable IP teams to recognize their strengths and weaknesses pertaining to collaborative practice (Schroder at al., 2011). Since another objective of this study was to investigate how IPC supports patient-centered practice, results from this questionnaire is believed to

assist the IP team in the Mental Health Unit with deciding collectively on the collaborative approaches for providing comprehensive, timely, and appropriate patient care (Schroder et al., 2011). The CPAT questionnaire was developed so practitioners could provide their views on working collaboratively, and analyze the similarities and differences in their views (Schroder et al., 2011). Schroder et al. validated this questionnaire through two pilot tests, which indicated it was a reliable diagnostic tool for assessing levels of collaborative practice with IP teams. The CPAT included three open-ended questions and 56 items cross nine domains including: mission and goals; relationships; leadership; role responsibilities and autonomy; communication; decision-making and conflict management; community linkages and coordination; perceived effectiveness and patient involvement (Schroder et al., 2011). Professionals were asked to rate their level of agreement across a seven-point Likert Scale, ranging from the lowest value of "Strongly Disagree" to the highest value of "Strongly Agree". The CPAT questionnaire needed to be adapted however to suit the particular design of this study, and therefore was shortened to 23 statements. The rationale for modifying the CPAT questionnaire is further explained in Section 3.2.

2.4 Analysis of Current Themes in the Literature.

The literature review studies were analyzed using a data extraction tool that categorized each study based on findings, designs, methodology, sample types and the year and context of the study, as shown in Appendix A. Findings commonly reported advantages and drawbacks to establishing interprofessional collaborative care (Barker et al., 2005; Campbell et al., 2011; Haverkamp et al., 2011; HFO, 2010; Kilfoil, 2007;

Poochikian-Sarkissian et al., 2008; Shaw, 2008). Professionals positively correlate IPC with increased support, feeling valued and respected, and improved decision-making (Kilfoil). However, IPC is time consuming, especially for pay for service physicians involved, who consequently see fewer patients due to time constraints, and ultimately face a reduction in their profit (Poochikian-Sarkissian, et al., 2008). Kilfoil (2007) further adds that IPC imposes some challenges in maintaining patient confidentiality, especially in small communities with distinct interpersonal relations between professionals and community members. Challenges to treating patients with mental illness include a lack of facilities, programs, and human resources, as well as high workload among professionals (Kilfoil). Moreover, Salhani & Coulter (2009) suggest that micro-political dynamics were increasingly reported in the literature of IPC. For example, Occupational Therapists and Registered Nurses see themselves as superior in terms of communication, interpersonal and practical skills in comparison with psychiatrists and psychologists. Also, the existence of unequal participation amongst nursing staff (charge nurse and assistant nurse) and medical staff (interns, residents, and full time physicians) was frequently reported by a number of studies (Atwal & Caldwell, 2005; Mann et al., 2009; Poochikian-Sarkissian et al., 2008; Reeves et al., 2009). Growing literature is found to offer ways by which IPC and IPE can be accomplished; yet it ignores the resultant constitution of competitive and political systems of interprofessional teams (Salhani & Coulter).

Patient involvement in IPC

2.4.1 Patient experience and outcomes.

Numerous studies identified benefits of using IPC in the patient-centered interprofessional practice settings, as they enhance the patient's experience and treatment outcomes. For example, HFO (2010) reported service improvements to patient care delivery including increased access to healthcare and improved outcomes for people with chronic diseases. Also, healthcare professionals and social services workers reported that teamwork facilitated treatment of mental health issues because it provided comprehensive care that assisted in keeping patients in their home community (Kilfoil, 2007). IPC has positive effects on the delivery of care and resulted in statistically significant outcome differences in patient mortality rates. Kilfoil also stated the collaboration of qualified professionals interacting was effective for specific patient populations including geriatric evaluation and management, congestive heart failure, and neonatal care and screening, and improved the delivery of care to patients. Furthermore, Zwarenstein, Reeves and Perrier (2005) examined the effectiveness of pre-licensure interprofessional education and the post-licensure collaboration interventions. This study argued it was difficult to measure effectiveness of pre-licensure interventions, but reported positive patient outcomes with post-licensure interventions by proposing that measures of health status outcomes, disease incidence rates, mortality rates, readmission rates, adherence rates, costs, and patient or family satisfaction, all strongly correlated to improved patient care and reduced costs.

2.4.2 Involving patients in the decision-making process of IPC.

Effective IPC is dependent on six competency domains, as outlined by the National Interprofessional Competency Framework (Canadian Interprofessional Health Collaborative [CIHC], 2010). One domain is patient/client/family/community-centered care, which is sharing information with patients in a way that is understandable, encourages discussion, and enhances participation in decision-making. In patient-centered collaborative practice, patients are seen as experts in their own lived experiences and are critical in shaping realistic plans of care (CIHC, 2010). Campbell et al. (2011) stated clinical decision support and decision aids are methods used to educate patients and encourage their participation in decisions involving their medical care. These aids are specifically designed to encourage a shared decision-making process between the patient and provider. Shared decision-making for a person with psychiatric disabilities has been identified as an implicit part of the recovery process. Campbell et al. (2011) suggested active involvement by the patients in their recovery process showed significant improvements in clinical outcomes in primary care settings for people with depression. Although the concept of shared decision-making with patients has been discussed in a few studies (Campbell, Stowe & Ozanne, 2011; Col, 2011; Lown et al., 2011; Politi et al., 2011), a shared decision-making process between the healthcare provider and patients with psychiatric disabilities, including the use of patient decision aids, has seldom been researched and discussed in the mental health literature (Campbell et al., 2011). Future research should further establish the active role of patients in interprofessional care. Launching a provincial IPC campaign to acknowledge the healthcare sector

accountability in the promotion and facilitation of IPC leadership development is recommended to successfully integrate IPC into the healthcare system (HFO, 2010).

2.4.3 Barriers to IPC.

Some barriers to IPC include time consumption, especially for physicians under the fee-for-service pay structure, and also the difficulty of maintaining patient confidentiality in small communities (Kilfoil, 2007). Kilfoil (2007) proposed other challenges for treating mental illness such as the lack of facilities, programs as well as high workload between professionals. Unfortunately, many professionals were poorly trained in mental health and had minimal experience in treating mental illness. There were also insufficient resources to coordinate mental health services.

Barker et al. (2005) identified other barriers such as unrealistic expectations about other disciplines, professional knowledge boundaries, professional culture differences, and a lack of knowledge about other professions' expertise, skills, training, and theory. Individual professional disciplines became protective of their own territorial turf and only engaged in interactions with members of their own disciplines. It was also reported that the medical profession posed challenges in terms of cultural beliefs about collaborative practice and interprofessional practice, as they were more resistant to reaching out to and joining with other professional groups (Barker et al., 2005). In addition to the work overload barrier, unplanned patient discharges and inadequate communication amongst team members contributed to difficulties in implementing a patient discharge plan (Watts et al., 2006).

Patient involvement in IPC

The National Interprofessional Competency Framework (NICF) addresses the issue of interprofessional communication and role clarity (CIHC, 2010). Role clarification is one domain in which practitioners are required to describe their own roles and that of others, while also recognizing the diversity of other health and social care roles, competencies, and responsibilities. Team functioning, collaborative leadership and interprofessional conflict resolution are also other domains proposed by this Framework to develop and maintain interprofessional working relationships, which consequently facilitate optimal health outcomes.

2.4.4 Professional identity.

Profession specific stereotypes exist since students complete their professional programs and begin careers with certain perceptions or understandings of other professions (Ateah et al., 2010). Professions have traditionally achieved power, status and the rights to practice by virtue of their knowledge and areas of specialization. This resulted in the failure of professions to acknowledge and understand the roles of other professions, and led to the formation of segregation, ignorance and stereotypical attitudes towards other professionals. These perceptions remain as unchallenged ideas because the students seldom interact with students from other professions**.** Mitchell et al. (2011) suggested this threat originates from the perception that professional status may be lost or professional boundaries may be threatened, thereby increasing professional solidarity and salience, and sharpening the defence of interprofessional distinctions. Threat to professional identity is defined as a perception of risk regarding the diminishing of a profession's expertise, values or occupational role (Mitchell et al., 2011).

Patient involvement in IPC

Atwal & Caldwell (2005) conducted direct observations and reported the existence of unequal participation among nursing staff (charge nurse versus assistant nurse) and medical staff (interns and residents versus full-time staff physicians). Hence, they concluded that it would be beneficial to better understand intra-professional communication patterns before attempting to look at inter-professional communication. Key informant interviews conducted by Barker et al. (2005) with healthcare professionals illustrated that professional "turfs" are important to consider, and the difficulties of changing entrenched professional beliefs and cultural prescriptions of how to educate healthcare professionals act as a barrier to the success of IPC and IPE initiatives. Haverkamp and colleagues (2011) proposed that family physicians reported a lack of familiarity with the scope of practice and training of psychologists, and how that training differed from the training of non-regulated professionals. As a result, the rate of participation by psychologists in the health sector is low as they are not included in the publicly funded system, and continue to face challenges in collaborative teams in the health sector. One reason suggested was that physicians and psychologists have limited knowledge of the culture and content of each other's work. To overcome this challenge and induce greater participation, psychologists need to familiarize themselves with the operations of the healthcare sector, including rules and power structures (Haverkamp et al., 2011). Findings by Ateah et al. (2010) suggested that learning together in an interprofessional environment can positively impact the perceptions of other health professions. Following participation in interprofessional education sessions, students in this study rated all participating healthcare professionals higher than they were rated prior to the interprofessional educational experience. Therefore it was concluded that such

early learning experiences can help students establish effective and collaborative working relationships in the healthcare team (Ateah et al., 2010).

2.5 Current State of IPC Care and Gaps in Literature

HFO (2010) proposed that implementing IPC and establishing a firm base for IPE requires the commitment of a range of stakeholders, including regulatory bodies, healthcare professional organizations, academic institutions, hospitals, insurers, community and support agencies, organized labour, researchers, patient/consumer groups, government, crown agencies, healthcare professionals, educators, administrators, patients, and families. HFO developed an Integrated Interprofessional Education Model to act as a guide for teaching and assessing interprofessional competencies. Fortunately, a commitment to IPE across Ontario was found and could be sustained through sharing the knowledge of IPE with schools and organizations concerned with health sciences education (HFO, 2010). Campbell et al. (2011) suggested that initial and continued training is required for successful implementation of interprofessional decision support. They proposed that financial incentives such as paid time off for training and paying for accommodations and transportation could potentially support professional training. Nonetheless, there remains a gap in literature such that there is a lack of evidence to confirm the provision of incentives and compensation, and how they could in fact engage in teamwork.

The Australian study by Mitchell et al. (2011) stated the professionals' commitment to their team enhances the team members' ability to work together cooperatively. They also proposed that management of interprofessional teams should

incorporate interventions that focus on developing shared goals, and a shared sense of interdependence that contributes to team attachment and identification. The professional's connection and commitment to the community seemed to strengthen collaborative practice. However this was a finding that has been rarely discussed in the Canadian literature to date.

Moreover, it was evident from the sample types of the 30 studies that they primarily included healthcare personnel such as registered nurses, occupational therapists and physicians. It is imperative to understand that a diverse team of professionals including psychiatrists, primary care physicians, psychologists, social workers, registered nurses, case managers and peer support specialists is required for high quality care in the mental health setting (Campbell et al., 2011). Consistency in decision support interventions in psychiatric settings requires participation from all of these groups to assist patients with their treatment decisions. Nonetheless, there are few data and limited guidance about how to implement interprofessional practice in the delivery of decision support to patients with mental illness (Campbell et al.) Also, very little has been reported on other healthcare workers (e.g. social workers, occupational therapists, etc.). Of the 30 studies identified for review, only two focused on the role of all healthcare professionals and social workers involved in the IPC process. It is important to include other healthcare professionals when investigating the perceptions and facilitators of IPC, as they also deliver services that impact patient outcomes.

Another gap in IPE materials existed for "collaborative leadership" and "interprofessional conflict management" (HFO, 2010). Competency frameworks have

been developed over the past few decades to identify the knowledge, skills, and behaviours required to be a successful practitioner in any profession (CIHC, 2010). These frameworks mainly focussed on the regulation of professional practice, such as the Canadian harmonized entry-to-practice competency framework for nursing graduate. Although these frameworks acknowledge the significance of IPC and teamwork, they do not provide an explicit direction for interprofessional practice (CIHC, 2010).

2.6 Implications

This study addresses various gaps found in the literature to date for collaborative mental healthcare. IPC is increasingly linked to patient-centered care, but the role of patients in the collaborative process is not always made clear. Kilfoil's (2007) study at the rural mental health facility in Newfoundland reported the absence of dedicated resources to coordinate mental health services, and suggested that professionals IPE and training programs are necessary to promote collaborative patient-centered practice as a practice orientation (Margison, 2009). Haverkamp et al. (2011) reported that psychologists are under-utilized despite the fact that this report also confirmed 70% of consultations with family physicians involve psychological problems and concerns. Also, most mental health services are delivered in the private sector and available to only few Canadians. There remains limited data and little guidance about how to implement interprofessional practice in the delivery of decision support to patients with mental illness (Campbell et al., 2011). Therefore, this study investigates how patients contribute to their own healthcare within a collaborative mental health setting, and the impact of patient engagement on their patient-centered experience. The study also compares the

patient and provider's roles and experiences in order to identify barriers to collaborative practice, and provides recommendations to improve the delivery of patient-centered care at the Mental Health Unit.

CHAPTER 3

Methodological Approach

3.1 Introduction

This case-study adapted a mixed-method approach with contextual observations, survey and one-on-one interviews. The study began with contextual observations of IP team meetings to gather information about the collaboration between IP team members and identify how patients were involved at the Mental Health Unit. The CPAT questionnaire was distributed to the IP team members to evaluate the strengths and weaknesses of the team's collaborative approach and understand their perceptions of patient-centered care. Then one-on-one interviews with patients were conducted to document and analyze their experiences during their stay at the Mental Health Unit. There were also one-on-one interviews with the IP team professional to identify how they involved patients in the collaborative care process.

The research questions investigated for this study were:

I. How does Interprofessional Collaboration support patient centered-care at community-based mental health settings?

II. To what extent is the patient involved in the IP team?

To answer these questions, the study began with contextualized observations of daily interprofessional team meetings to understand the functionality of the IP team at the Mental Health Unit (Appendix B). This was followed by semi-structured interviews with

patients and healthcare and social care professionals to gain a better understanding of how patient-centered practice and patient involvement are implemented during interprofessional (IP) meetings (Appendix C). Finally, the Collaborative Practice Assessment Test (CPAT) questionnaire was modified for this study (Appendix D) and distributed to professionals to compare the professionals experience with that of the patients'. The rationale for modifying this questionnaire is explained in Section 3.5.1. The questionnaire had a mixture of open and closed-ended questions that were analyzed (Chapter Five) and used to complement findings from the observations and interviews (Chapter Four). The responses to these questions were believed to aid in identifying the extent to which patients were in fact involved and identifying approaches for improving the patient-centered practice from the perspective of both patients and healthcare and social care professionals.

3.2 Research Methods

The field of health research encourages combining qualitative and quantitative research methods, given the practical nature of the discipline and the complexity of factors affecting health and healthcare (Neutens & Rubinson, 2010). Mixed method designs have been defined as the use of qualitative and quantitative methods in parallel or sequential phases, with the goal of having one method enhance the performance of the other (Bowling & Ebrahim, 2005). Thus, qualitative and quantitative methods were integrated in this study at the data collection phase because the inclusion of quantitative study designs as well as qualitative methods in this study could shed more light on the relationship of the variables supporting the success of IPC initiatives (Barker et al.,

2005). Most of the literature on the topic of IPC is based on qualitative methodology. As stated by Barker et al., qualitative research is a means of exploration which can inform future research, including investigation about whether the factors identified by the participants in the study are applicable to other populations and in other professional settings.

The study used a mixed method case-study approach with a purposive sample of healthcare and social care professionals, and inpatients at the Mental Health Unit. In particular, this was an explanatory case-study design which was used to answer the "why" and "how" research questions (Yin, 2003). The case-study is preferred in examining contemporary events, such as interprofessional team meetings in this study, and relies on direct observation of the events being studies as well as interviews of the individuals involved, including inpatients with mental illness and healthcare and social care professionals. Case-studies are useful for studying educational innovations, evaluating strengths and weaknesses of programs, and informing policy so modifications can be instituted (Merriam, 2009). They also offer means of investigating complex social units consisting of multiple variables that are important for understanding a phenomenon. Case study methodology plays a critical role in advancing a field's base knowledge, especially for applied fields of study such as health and social work (Merriam, 2009). This enabled the Principal Investigator (PI) to comment on the operations of the IP meetings and the extent of patient involvement, and establish why and how patient discharges were "chaotic at times" as described by the Patient Care Manager at the Mental Health Unit. The case study methodology was best for this project because this type of design results in a rich and holistic account of a phenomenon, and offers insights

that can affect and perhaps improve practice. This design was ideal for answering the research questions investigating how the process of interprofessional collaboration promotes patient-centered practice and how patients are involved.

As with all study designs, case-studies also have limitations. One is that it focuses on a single unit or instance, such as the Mental Health Unit in this study. This adds to the issue of generalizability. According to Polit, Beck and Hungler (2001) generalization is an act of reasoning that refers to making an inference about the unobserved based on the observed. Generalizability is used to evaluate the quality and external validity of a study. However, many researchers do not agree about the importance of generalizability as it requires extrapolation that cannot be fully justified since findings are context-based (Polit et al., 2001). In nursing and other applied areas of health research, generalizations are critical to applying the findings to people and situations other than those in a study (Polit et al., 2001). Moreover, producing a worthy case study may require a lengthy detailed description and lengthy analysis of the phenomenon (Merriam, 2009). Yet the product may be too lengthy, very time-consuming and too involved for participants, professionals and patients in this study. To overcome this limitation, this case study involved different stages of data collection in which multiple and key professionals had the chance to participate in either a questionnaire or interview stage. Data from all sources were used to complement the findings from patient interviews.

Furthermore, case studies are limited to the integrity and sensitivity of the investigator, who may not have training in observation or interviewing prior to commencing the study. The study then becomes limited to his own instincts and abilities.

Patient involvement in IPC

To overcome this barrier and prior to data collection, the PI met with her research team who have professional expertise in research applications and methods, and extensive research experience and knowledge of interprofessional collaboration. First, it was agreed that the PI conduct the contextual observations under the supervision of the Mental Health Unit's Patient Care Specialist who is also a research partner and a member of the Supervisory Committee for this research. Second, a semi-structured format was developed with the help of the Supervisory Committee and was followed for all interviews to maintain focus on the objectives of the study.

3.3 Sample

This study used a non-random sampling technique in which participation was completely voluntary. The sample was purposive and composed of two groups: patients and healthcare and social care professionals. Professionals included psychiatrists, registered nurses, nurse practitioners, patient care manager, and social workers who all participated in the interprofessional team meetings at the Mental Health Unit and met the inclusion criteria as stated in Section 3.3.2. The sample size was based on the voluntary participation of subjects, with an aim of having 10 professionals and 10 patients, as per the collective sample sizes of mental health literature studies (Barker et al., 2005; Salhani & Coulter, 2009; Kilfoil, 2007; Margison, 2009; Parker et al., 2011; Schroder et al., 2011; Watts, Pierson & Gardner, 2006). For purposes of analysis, healthcare professionals were allocated into three groups to ensure anonymity in responses, and allow a more discrete intra- and inter-group analysis. Firstly, the Medical Leads was the group primarily composed of physicians. This group consisted of the primary decision

makers for treatment and discharge plans, as noted by the investigator in the contextualized observations of IP meetings (see Appendix B). The second group was comprised of bedside and clinical support workers including registered nurses, patient care manager, and nurse practitioners. Lastly, the Allied Health group included all other professionals involved in the IPC process, such as social workers, community partners, and psychologists. The groups were created for the purpose of analysis which was supported by Krippendorff's idea for survey research (2013, chap. 5). According to Krippendorff (2013, chap. 5), sampling units are distinguished for selective inclusion that aids with the analysis of a study. In survey research, units are those individuals answering questions, for example the healthcare and social care professionals in this study. Units can be defined by their membership in a class or category, as they have something in common and this is used for analysis purposes (Krippendorff, 2013, chap. 5). Hence, the healthcare and social care professionals group in this study was categorized based on their decision-making authority and participation in IPC meetings to further aid with the analysis of results.

3.3.1 Setting and participants.

The study took place at the acute setting of a Mental Health Unit at an urban Canadian community hospital in Ontario. IPC had already been incorporated into the hospital's mental healthcare programs. Inpatients had an average stay of seven to twelve days, and were then discharged to continue their treatment upon stabilization, into the appropriate settings such as their own homes, nursing homes, emergency community housing, tertiary facilities, and addiction counselling for detox and/or case management.

3.3.2 Inclusion criteria.

The inclusion criteria for healthcare and social care professionals include physicians, social workers, community support workers from Durham Mental Health, Pinewood Addiction Center and the Canadian Mental Health Association (CMHA), case managers, registered nurses, charge nurses, psychologists, and psychiatrists who have been practicing, for over six months or for at least three months post-return from a short-term work-leave at the Mental Health Unit where this study is taking place. This timeline is important because newly hired individuals are placed in a six month probationary period at the hospital to demonstrate their skills and competencies for the job. Their contracts are only extended after the successful completion of this probationary period, and only then they will have gained working knowledge of the Mental Health Unit. Similarly for those returning from a leave, a post three-month period is necessary to ensure these individuals have completed a smooth transition back into the culture of the Unit. Hence, they can provide comments and insight which more accurately reflect their experiences of interprofessional team meetings, collaboration between team members, and any evidence of patient involvement at the Unit.

The inclusion criteria of patients included males and females between the ages of nineteen to 70, who were admitted as inpatients and received primary care at the Mental Health Unit. They received care from at least two healthcare and/or social care professionals, and have been approved by their Patient Care Specialist and caring nurse to participate in this study to ensure the interviews will not cause them anxiety issues. Inpatients had to be cognitively stable as per physicians' diagnosis, displayed the

capacity and experience to comment on professional's behaviour and treatment, and had the ability to self-manage their daily living activities. Details on how this was determined are further explained below in Section 3.4.3 of the Sampling Method section. Patients included were specifically diagnosed with depression and/or schizophrenia and/or anxiety and/or psychosis and other mood disorders. These specific criteria of illness were set because those were patients seen by the most variable groups of professionals within the interpfessional team, and their mental illnesses were most prevalent among patients with mental illness at the Mental Health Unit.

3.3.3 Exclusion criteria.

Exclusion criteria for the group of professionals included residents and medical students, and those who did not qualify under the inclusion guidelines. The sample excluded professionals working night shifts, for the hours of 19:00 to 07:00 since they do not participate in the clinic's morning IPC meetings. The patients excluded were those diagnosed as cognitively nonfunctional, experiencing a state of crisis, and with a new chronic condition. Patients that were acutely suicidal, and/or suffer from neurodegenerative diseases (dementia) and/or Alzheimer's as comorbidities, were also excluded since they no longer had the capacity to provide consistent responses and may skew the results. Details on how this was determined are further explained below in Subsection 3.4.3 of the Sampling Method Section.

3.4 Sampling Method

3.4.1 Pre-study contextual observations.

Pre-study observations were completed to understand nature of interactions among professionals and the functionality of interprofessional team meetings at the Mental Health Unit. Another purpose was to investigate how decisions concerning patient treatments and discharge were made, as well as investigate any evidence of patient involvement in the decision-making process.

These observations also aided in identifying key informants for the interviews. Permission from the interprofessional team was given prior to conducting the observations during the Interprofessional (IP) meetings, and observations were conducted under the supervision of the Patient Care Specialist. Pre-study activities consisted of observing seventeen weekly interprofessional team meetings at the Mental Health Unit from May to July 2012. This was conducted primarily to develop familiarity with the individuals and setting of the Mental Health Unit, and was a foundational step in later guiding the development of this study design. IP meetings take place at the Mental Health Unit to gather all professionals and discuss patient treatment interventions and discharge plans. Moreover, the PI attended two daily IPC meetings, both of which included the mental health team. The first morning meeting took place at 8:30am at the Emergency Department, and included social workers, registered nurses, a physician, community partners from the Regional Mental Health Association (RMHA) and Canadian Mental Health Association (CMHA) as well as one of the Patient Care Manager or Patient Care Specialist from the Mental Health Unit. This meeting mainly took place to update the IPC

team at the Emergency Department with vacancy at the Mental Health Unit, number of beds currently occupied, as well as any potential discharges planned thereby creating vacancy for new admissions seen by the Emergency Department team.

The second IP meeting took place at the mental health clinic at 8:50am, and involved the same staff aforementioned as well as the remaining group of registered nurses and team members working at the Mental Health Unit. This meeting involved discussion of each inpatient conditions, treatments and subsequent discharge plans. The Patient Care Manager and Patient Care Specialist who led this IPC meeting also communicated all patient cases to be admit7ted into the Mental Health Unit as discussed at the previous 8:30am IP meetings. This was a critical step so the PI was better able to identify those professionals who were more frequently involved during the IP meetings and would more likely be willing to participate in the study as key informants.

3.4.2 Sample of professionals.

The PI personally distributed the consent forms and questionnaires to eligible healthcare and social care professionals to invite them to participate in this study. This took place during three tea meetings (Tea for the Team Express- T4T Express), held for the IP team at the Mental Health Unit conference room. The Mental Health Unit Patient Care Specialist specifically organized the times for these T4T Express events, occurring weekly starting April 25th to May 9th 2013, for approximately one hour each. A small advertisement (Appendix E) for this study was displayed in the conference room and registered nurses' room at the mental health unit to promote participation in these events. The Patient Care Specialist was not present during these events to avoid any

coercion imposed on staff due to his role as the research supervisory committee member and the supervisor at the Mental Health Unit. Thus, he was excluded from the recruitment process, and had no knowledge of which staff chose to participate or not. T4T Express events were solely used to promote the study objectives investigating the experiences of patients and professionals with IPC and identifying the extent of patient involvement in the care process. Moreover, the events were used to increase staff participation rate, during which the PI also requested the return of the signed consent form and questionnaire answers upon participant approval of being included in the study. Healthcare and social care professionals filled out consent forms (Appendix F) and the modified CPAT questionnaire to provide their views on IPC and the extent of patient involvement in the patient care plans at the Unit. This took no more than twenty minutes to complete, which was why the PI asked interested participants to individually fill out and return the questionnaire (and consent) in 48 hours after the T4T Express event, as this did not allow group discussions and prevented potential group bias. The consent form asked participants permission to also be invited for an individual interview with the PI, which would be audio-taped and transcribed. Once completed, the questionnaire were returned to the PI, each in separate and sealed envelopes with numerical codes only, and without any labels identifying the participant's area of specialty or name. The PI created a separate professional identifier list linking these professional's identity and area of specialty with numerical codes, which will be kept only by the PI, and remain strictly confidential as no other individual has access to it. This list consisted of numerical codes of "p1," "p2," …etc., and serves the purpose of protecting the professionals' confidentiality. Also, information from the modified CPAT questionnaires was kept

separately from this identifier list in a locked, safe drawer at the University of Ontario Institute of Technology (UOIT) Faculty Supervisor's office, and names were not marked on either the questionnaire or envelopes.

3.4.3 Sample of patients.

The sample of patients was selected randomly from April 25th to June 6th 2013 by the Patient Care Specialist who was the PI's research partner, using the attending physician's diagnosis stated on the mental health unit's Patient Care Unit Census. This Census is a daily list of inpatients at the Mental Health Unit specifying details of their age, diagnosis, attending physician, length of stay, and their respective family physician. The Patient Care Specialist followed the inclusion/exclusion criteria stated previously, during the patient selection process. Afterwards, he passed on the names of eligible patients to the caring nurse on the floor, who then approached patients to obtain a verbal consent for the PI to contact them. The nurse asked a specific question "can I get permission to be contacted by a student researcher, the PI, to explain the study that she needs your help with?", and the patient signed at the time of agreement. The Patient Care Specialist, the attending physician and the caring nurse were not present during patient interview to mitigate the risk of feeling pressured and potential conflict of interest. Upon permission to sit in for an interview, the caring nurse was asked to be present outside the room in which the interview took place with the PI. This was to ensure the PI could get the nurse to escort the patient immediately once completed and/or stopped at the patient's request. The PI informed patients about the study in detail, and obtained signed consent forms prior to proceeding with the interviews. She also created an identifier list of

patients; the first person interviewed will be "pt 1," second patient will be "pt 2," …etc., to maintain confidentiality.

3.5 Data collection and tools

3.5.1 Questionnaire.

As previously mentioned in Section 2.2, the Collaborative Practice Assessment Test (CPAT) includes nine domains: missions and goals, general relationships, team leadership, general role responsibilities, communication, community linkages, decision-making and conflict management, perceived effectiveness and patient involvement. Respondents were asked to rate their level of agreement with each of the 57 statements along a seven-point scale ranging from the lowest value of 'Strongly Disagree' to the highest value of 'Strongly Agree', and answer additional open-ended questions (Schroder et al., 2011). The questionnaire was shortened to 23 statements (Appendix D) to suit the particular design of this study. The statements chosen were those the PI found relevant to the purpose of this research project for identifying the role of patients with interprofessional teams and how interprofessional collaboration could support patient-centered practice. The 23 statements were also chosen to address the gaps identified in the current mental health literature as proposed in Chapter Two which indicated there were limited data about patient involvement with interprofessional teams and little guidance about how to implement interprofessional practice in the delivery of decision-support to patients with mental illness (Campbell et al., 2011). The Supervisory Committee's insights were shared and used to modify the CPAT questionnaire. Statements chosen for the modified CPAT were directly related to the objectives of the

study and the six competency domains of the National Interprofessional Competency Framework (NICF) which were developed to improve the effectiveness of IPC (CIHC, 2010). The domains include interprofessional communication, role clarification, team functioning, patient/client/family/community-centered care, collaborative leadership and interprofessional conflict resolution (CIHC, 2010). NICF was used to analyze interview and observational data. The statements chosen were also based on the recurring issues identified from the pre-study observations of IPC meetings (see Appendix B) at the Mental Health Unit, twice a week during the months of May to July 2012. Ultimately, the PI used the modified questionnaire to measure domains specific to the study, including: professional's goals and perceptions of IPC, team leadership, relationships and role responsibilities, communication, and community and patient involvement in the process of IPC. Focussing on the items of interest for this study reduced the length of the questionnaire which had the potential to increase participation rate as well.

3.5.2 Semi-structured interviews.

Interviewing is an ideal method to collect data on the experiences of participants during various stages of the research process, and semi-structured interviews benefit the interviewer by ensuring all question areas are covered using a written guide, while still allowing the participants to talk freely and allow the researchers to collect more data (Barker et al., 2005).

Patient involvement in IPC

3.5.2.1 Interviews with professionals.

Semi-structured interviews were conducted with key informants identified based on their degree of participation during the IP meetings. A key informant is an expert source of information (Marshall, 1996). Tremblay (1989) states an ideal key informant should demonstrate willingness to communicate their knowledge to the interviewer and cooperate as fully as possible. Registered Nurses and Social Workers who consistently participated in IP meeting were willing to cooperate and share their professional experiences during interviews and provide their input openly. They were more involved and familiar with the operations of the Unit; thus were better able to comment on the major themes of the study such as how IPC was implemented, communication between professionals and extent of patient involvement.

Interviews were semi-structured based on the observations made, and were associated with the domains of the modified CPAT questionnaire, and the domains of the National Interprofessional Competency Framework as previously listed in section 3.6. The purpose of conducting interviews with professionals was to gain a deeper understanding of the professionals' roles and the nature of interactions among the interprofessional (IP) team. Each interview took between 30 to 60 minutes in length, and was audio-taped and transcribed. The interviewer and transcriber is the same person (PI), and the only one able to identify the participants. Similar to the identifier list created for the modified CPAT respondents, the PI created a second professional identifier list linking the identity of professionals interviewed with numerical codes, which was only kept by her and remained strictly confidential as no other individual had access to it. This

list consisted of numerical codes of "p1 interview," "p2 interview," …etc., and served the purpose of protecting the professionals' confidentiality. The Patient Care Specialist did not know who participated in these interviews, and did not have access to interview notes or transcripts. For data storage and archiving, the audio-tape and any written information from the audio-tape were kept with the PI in a secure locked filing cabinet at the Faculty Supervisor's office once the interview was completed. Only the PI had access to this identifier list. Names were not marked on either the tape or any paper material. Participant contributions remained strictly confidential, and participants were not identified in any part of this study.

3.5.2.2 Interviews with patients.

Interviews with eligible patients were conducted to measure the patient's impressionable experience of IPC as well as investigate the patient's contribution to the IPC process. The interviews with eligible patients were guided by interpretive questions adapted from a Canadian study at the Toronto Western Hospital Family Health Centre by Shaw (2008). All interviews lasted 30-60 minutes in length, and were recorded with digital audiotape (Sony Dragon Digital Voice Recorder ICD-PX333D) upon patient consent, then transcribed by the PI.

Consent for participation was obtained at the beginning of the interview, and participants were reminded not to use staff or patient names during the interview. Confidentiality agreements were signed by the PI and Patient Care Specialist. In this study, confidentiality of patients and professionals participating is an important aspect of the research design, as approved by the University and Hospital's Research Ethics Boards

(REB). Confidentiality of participants was protected such that no identifying information of participants was revealed, and results were reported without identifying any informants. The PI informed patients about the study in detail, and collected signed consent forms prior to proceeding with the interviews. Ongoing consent was sought. As previously indicated, this study focused on patient-centered care, and the patient was an active part of the treatment plan at the Mental Health Unit.

On the day of the interview, the PI confirmed with the caring nurse that patient stability was maintained and whether there was any doubt of the patient's capacity to participate due to a disturbed state or change of medication. Also, the PI would not carry on with the interview if the patient had scheduled activities, visits or appointments at that same time, or if the patient arrived in an agitated state. The attending physician would be contacted to re-assess the patient's eligibility and consent would be re-taken. On-going consent would be reviewed and any basis of the patient being unable to give informed consent under the original agreement, due to change of medication or state disturbance, the interview would be rescheduled until patients were fully capable of participating as per the physician's orders. All participants have the right to withdraw from the study at any point they wish to do so, and this was stated in the patient consent forms as well as at verbally stated the beginning of the interview. Participants were free to contact the University's Compliance Officer or the Hospital's Chair of Research Ethics Board with any questions. Upon request of withdrawal, participant consent forms and any data, including audio/transcript records collected prior to their withdrawal would be removed from study results, and kept unused, and locked in a filing cabinet at the UOIT Faculty Supervisor's office, for regulatory purposes.

Patient involvement in IPC

The caring nurse acted as the professional care escort for patients participating in the interviews, and was responsible for escorting patients to and from the conference room for interviews as per REB criteria. The interview would be terminated immediately if the patient became incapacitated and/or withdrew consent to proceed because of feelings of anxiety and depression involving the interview, its content and dynamics. In the first instance, the care escort would escort the patient back to his/her treatment locality. The need to follow-up would be communicated to the supervisory care giver guided by the principle of sensitive referral.

The PI eliminated any identifiable information, together with any information breaching professional and/or patient confidentiality in the study. Interview transcripts produced were reviewed by the PI to verify its content, thereby ensuring validity of resultant findings, as well as further maintaining confidentiality of the subjects.

Patients interviewed by the PI were assigned numerical labels, and this list was kept in a secure locked filing cabinet at the Faculty Supervisor's office. Only the PI had access to this identifier list. Data produced was all assigned numerical labels, rather than personal names, and were stored in another locked filing cabinet at the Faculty Supervisor's office, to which only the PI had access to. The Patient Care Specialist did not know which patient participated or not. He only had access to the original hospital Census with patient names that met the inclusion criteria, but did not communicate the data of this Census with any team member to maintain patient confidentiality. This Census is stored at a locked drawer at the Patient Care Specialist's office, to which no one else has access. Following completion of this study, consent forms and all study data,

including audio and transcript records collected would be kept for seven years as required, then destroyed immediately as per the Faculty of Health Sciences policy at UOIT. Written data would be shredded and the voice recordings would be deleted permanently from the device. Similarly, the USB flash drive with data related to this study would be inserted into the computer and its contents removed. Then the USB flash drive would be physically broken by the PI (with a hammer) and thrown in the trash to ensure safe disposal.

3.6 Data Analysis

This mixed-method study utilized three data analysis approaches: descriptive statistics, thematic approach and the framework approach.

Descriptive statistics completed with *Microsoft Excel 2010* were used to analyze quantitative data from the questionnaires. The modified CPAT questionnaire covered domains specific to this study: leadership, communication, community linkages, and patient involvement. On the other hand, the National Interprofessional Competency Framework (NICF) approach guided the analysis of qualitative data from patients' and professionals' interviews and IPC meeting observations. The NICF is dependent on six competency domains including interprofessional communication, role clarification, team functioning, patient/client/family/community-centered care, collaborative leadership and interprofessional conflict resolution (CIHC, 2010). Furthermore, the qualitative software *NVivo 10* (QSR International, 2014) was used to organize, identify trends, and analyze data collected. This marked the thematic approach which was utilized to further develop codes, or themes, relevant to the framework's domains, and examine relationships in the

data from interview transcriptions and questionnaire results. It also included comparing sections of texts in the transcripts, coding and reorganizing of the text, as well as displaying data to form a conceptual theme or pattern specific to the variables of this study. To ensure the rigour of this study's findings, a secondary reviewer was given three unlabelled transcripts and a questionnaire to code the data using specific themes. The transcripts were for a Registered Nurse, a patient with Depression, and another patient with Depression and Post Traumatic Stress Disorder. This step was also taken to confirm reliability and credibility of the coding scheme used for analyzing the data. The reviewer was also required to sign a confidentiality agreement.

3.7 Ethical Considerations

Ethics approval from the Research Ethics Board at the University Of Ontario Institute Of Technology (UOIT 12-013) was obtained as of January 31, 2013. The study also obtained approval from ethics at the hospital (RID# 2013-009) and data collection commenced in April 2013. After the approval of RID# 2013-009, consent forms were distributed to study participants, including healthcare and social care professionals and eligible patients as per inclusion/exclusion criteria.

It was stated in the consent forms to all participants, as well as verbally prior to interviews that they do not have to answer any questions they do not wish to answer. As well, participant consent forms for professionals and patients each indicated their right to withdraw from the study whenever they wish to do so, without any consequences to discontinuing their participation. Moreover, the participants could contact the social

worker at the hospital if they experienced any questions, concerns or felt uneasy or anxious.

Additionally, to manage the psychological risk on patients, the Patient Care Specialist and caring nurse initially approved of the patients' capacity to participate without undue emotional stress or anxiety. The Patient Care Specialist also confirmed the inclusion criteria and eligibility in the study by randomly selecting patients from the Patient Care Unit Census. The caring nurse of each eligible patient obtained a verbal consent from each patient prior to allowing the PI to contact each of those patients. The nurse asked a specific question “can I get your permission to be contacted by a student researcher, the PI, to explain the study that she needs your help with?”, and the patient signed at the time of agreement. The Patient Care Specialist, the attending physician and the caring nurse were not present during patient interview to mitigate the risk of feeling pressured and potential conflict of interest. Upon patient approval of sitting in for an interview, their respective caring nurse on duty that day was asked to be present outside the room in which the interview took place with the PI. This was to ensure the PI could get the nurse to escort the patient immediately once completed, as well as for reasons such as providing immediate assistance if the PI and/or the patient felt unsafe or uncomfortable or if the patient suddenly became agitated and/or severely anxious.

All information and data collected were kept anonymous. The data were anonymous since the PI did not communicate the names of the participants she interviewed to the supervisory committee. Hence, participants were informed in the consent forms, that their personal information including name will not be published. The

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PI and the Patient Care Specialist were required to sign a confidentiality agreement at the hospital prior to commencing data collection. For data analysis and reporting purposes, The PI generated a separate identifier list for patients interviewed, such that they are assigned numerical labels (patient 1, patient 2 and so on...) and kept in a locked drawer at the faculty supervisor's office separate from the Patient Care Specialist's list. All data produced was stored in a secure, locked location, and only the PI had access to this data. Following completion of this study, the data will be kept for seven years as required, then destroyed immediately as per the Faculty of Health Sciences policy at UOIT, in January 2021. Only the PI had access to the interview voice recordings and transcribed each interview which was saved in a password-protected USB flash drive.

3.8 Validation

The modified CPAT questionnaire used in this study has been approved as a valid and reliable survey for measuring healthcare team members' perceptions of working collaboratively (Schroder et al., 2011). This study was a pilot to validate the modified version of the questionnaire which contained 23 rating statements and three open-ended questions. The CPAT needed to be adapted to the specific design and objectives of this study as listed in Section 3.5.1. The modified version of the CPAT was validated in context of working with the research partner at the Mental Health Unit and as a result of having this study recommendations implemented in the Mental Health Unit. These recommendations are further discussed in Chapter 6.

Moreover, triangulation refers to the combination of different study groups, methods and theoretical perspectives in dealing with a phenomenon (Flick 2007, chap.

14). Triangulation is used in this study to validate results obtained from different data collection methods. It is also used to formalize the association between quantitative and qualitative research as well as strengthen the quality of the research and its design (Flick 2007, chap. 14). There are different types of triangulation. First, data triangulation refers to the use of different data sources. Second, investigator triangulation minimizes bias using different interviewers or observers. Third, theory triangulation involves the use of multiple hypotheses and theoretical perspectives. Lastly, methodological triangulation involves the use of different methods such as interviews and observations, and it is the type used in this study to compensate for individual method limitation and combine their individual benefits (Shenton, 2004). The modified questionnaire and interviews in this study focus on the experiences and perceptions of all study participants. This is called a "within-method triangulation" and is used to emphasize confirmability based on subject perceptions to help reduce the PI bias (Shenton, 2004).

To sustain credibility of findings, debriefing sessions with the supervisory committee members took place throughout the period of this project to refine methods, explanations of design, and strengthen arguments if necessary. Another form of methodological triangulation in this project is the use of a wide range of informants from a sample of physicians, psychiatrist, registered nurses, psychologists, social workers, and patients. This ultimately provides a comprehensive assortment of perceptions and behaviour under scrutiny for this study.

3.10 Summary

In summary, this study used a mixed method approach to examine the patient-centred experience, patient's contribution to their care, and how the dynamic of patient involvement works with respect to interprofessional care at a community-based mental health setting. Observational data was initially collected during 16 weekly IP meetings at the Mental Health Unit. Specific inclusion/exclusion criteria were used and data collection included a paper-based questionnaire with open- and close-ended questions, as well as one-on-one in-depth interviews with twelve inpatients with mental illness and eleven healthcare and social care professionals from the IP team. The questionnaire included items to determine views on interprofessional care (IPC) and patient involvement and was distributed to professionals working in the community-based mental health setting. Data was analyzed initially with the aid of a thematic approach and the *NVivo 10* qualitative software. Then further analysis were developed using descriptive statistics and the framework approach guided by the National Interprofessional Competency Framework. Several measures were taken to protect participant confidentiality and anonymity as outlined. Debriefing sessions with the supervisory committee and triangulation methods were used to control bias, increase confidence in the findings and counteract the limitations of this study.

CHAPTER 4

Results

4.1 Introduction

Interprofessional collaboration is seen as key to promoting the recovery of patients with mental illness and enhancing services provided to them. This study looked closely at the patient-centered experience within a Canadian community-based mental health setting. It adopted a case study design with a mixed method approach, including a modified version of a validated questionnaire completed by a group of healthcare and social care professionals participating in the IP meetings. Observations of the IP meetings took place and later informed the selection of professionals that were interviewed. Lastly, patients with mental illness meeting the inclusion criteria and whose cases were discussed in the IP meetings were interviewed. This was to gain further insight on the patient-lived experience and extent of involvement in their care process. The final sample consisted of twelve inpatients with mental illness and eleven healthcare and social care professionals. The purpose of the study was to examine the contributions patients make to their care, and investigate how the dynamic of patient involvement worked with respect to interprofessional care. More specifically, the research questions were:

I. How does interprofessional collaboration support patient-centered care?

II. To what extent is the patient involved with the IP team?

4.2 Questionnaire Results

Twenty-three statements from the Collaborative Practice Assessment Test (CPAT) by Schroder et al. (2011) were used in this study. Respondents were asked to rate their level of agreement with each of the statements along a seven-point scale ranging from the lowest value of 'Strongly Disagree' to the highest value of 'Strongly Agree', and answer additional open-ended questions about the meaning of patient-centered care, whether patients can be part of the IP team, and whether patients were involved in treatment and discharge plans. They were instructed to place a number next to each statement corresponding to their response. A copy of the modified questionnaire is attached in Appendix D. The questionnaire included items on: 1) professional's goals, 2) perceptions of IPC, 3) team leadership, 4) team relationships, 5) roles and responsibilities, 6) communication, and 7) community and patient involvement in the process of IPC.

The results from this questionnaire, for each of the domains abovementioned, are presented in the following tables below, and provide a comparison of each professional's response. Twenty-two questionnaires were distributed, eleven of which were returned. All eleven questionnaires were included in the final analysis.

4.2.1 Description of the respondents.

The encoded list of professionals' (P) occupation for the questionnaires distributed is stated below in Table 4-1. The questionnaire also contained items on occupation, the number of years of service at the Mental Health Unit, and total number of

years of service at other hospitals and/or health facilities, as presented in Tables 4-2 and 4-3, and 4-4, respectively.

Table 4-1: Occupational Status, Total N= 11

P#	Response	Profession
1	Y	Registered Nurse
2	-	Nurse Practitioner
3	Y	Registered Nurse
4	-	Registered Nurse
5	-	Nurse Practitioner
6	-	Registered Nurse
7	-	Charge Physician
8	Y	Registered Nurse
9	Y	Patient Care Manager
10	Y	Nurse Practitioner
11	Y	Registered Nurse
12	Y	Registered Nurse
13	Y	Registered Nurse
14	Y	Registered Nurse
15	-	Registered Nurse
16	Y	Nurse Practitioner
17	Y	Registered Nurse
18	Y	Registered Nurse

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19	-	Social Worker
20	-	Registered Nurse
21	-	Nurse Practitioner
22	-	Social Worker
	Total 11	

Table 4-2: Occupational Status, Total N= 11

Occupation	**n**
Registered Nurse (Registered Nurses group/bedside caregivers)	8
Nurse Practitioner (Registered Nurses group/bedside caregivers)	2
Patient Care Manager (Medical Leads)	1

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Table 4-3: Years in the Profession at the Mental Health Unit, Total N = 11

Experience in profession	**n**
6 months to 1 year	3
More than 1 year to 5 years	3
More than 5 years to 10 years	2
More than 10 years to 20 years	2
More than 20 years	1

Table 4-4: Years in the Profession at other health facilities/hospitals, Total N = 11

Experience in profession	**n**
6 months to one year	1
More than 1 year to 5 years	4
More than 5 years to 10 years	2
More than 10 years to 20 years	2
More than 20 years	1
No answer	1

A total of eleven participants responded, with a 50% response rate. All respondents provided direct care to patients with mental illness at the Unit, and the majority of the questionnaires returned (eight) were by Registered Nurses. One respondent was a Patient Care Manager and two were Nurse Practitioners.

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The number of years in the profession ranged from six months to more than twenty years. Three respondents had 6 months to one year experience, three had more than one year to five year's experience, two had more than five years to 10 year's experience, two had more than ten years to twenty year's experience, and one respondent had more than twenty years experience at the Mental Health Unit in the community hospital.

For years of professional experience outside the Mental Health Unit: one respondent had 6 months to one year experience four had more than one year to five years experience , two had more than five to ten years experience , two had more than ten years to twenty years experience, and one respondent had more than twenty years experience at other hospitals/health facilities.

4.2.2 Questionnaire Open ended questions.

Question: What does patient-centered care mean to you? Who does it include?

Registered Nurses identified patient-centered care with care that is focussed around setting patient goals and treating the patient as a whole while including the patient, their family and a multidisciplinary team of professionals.

*"*It means that all interventions, treatments, are to promote patient care,"

"It includes both the healthcare team, the patient, and their families. Patient-centered care allows us to increase the satisfaction of the patient treatment, linkage, understanding, and community resources. Treating the patient as a whole,"

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"Viewing the patient as the center of the care being provided and soliciting the patient's input so as to provide the best professional care. Multidisciplinary team,"

"Holistic approach based on clients goals. Developing solid rapport and trust is mandatory and must be developed first, must be clients' goals,"

"Care that is based around the patient's specific set out goals,"

"PCC means we are looking at the patient as a whole; holistically. This may include anyone from RT, community supports to even patient's family."

"Patient being center of their care, them driving the care,"

Nurse Practitioners associated patient centered care with providing treatment and treatment options to the patient. They stated:

"Patient-centered care means that each patient is treated on an individual basis. This includes treatment based on person's mental status and level of wellness,"

"Discussing treatment options, providing information re-follow-up needs and if patients are committed to do so."

The Patient Care Manager described patient centered care as a way to assist the patient with identifying their concerns, setting goals and involving the multidisciplinary team as well as family and friends for support.

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"Patient-centered care is about the patient. What can we (interdisciplinary team) assist the patient who has identified issues and concerns and what goals the patient wants, to work on and with whom (family, friends, or supports)."

Question: How does your clinic advocate for patient involvement in treatments and in discharge planning, and why?

All Registered Nurses agreed the Mental Health Unit advocated for patient involvement via patient and family meetings, connecting patients with community resources and discussion of treatments. One Registered Nurse felt she was neither involved nor aware of the treatment and discharge planning for patients, however agreed the Unit involves patients by having mandatory groups scheduled as part of their treatment.

"We do hold interprofessional morning meetings which include outside agencies. We do participate in building and cementing relations with community stake holders."

"During patient and family meetings we are able to make them a part of the team, so that they may advocate for themselves. It makes them understand the system and understand what is going to happen to them, and how they can achieve it,"

"Allow the patient to freely discuss their needs and consideration of their opinions in providing care,"

"It is my job to advocate for clients' needs. As the client changes goals or develops new ones, we (should always) be seeking treatments and services as required,"

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"Weekly meetings are booked. EDD is set upon admission to start the process (to ensure timely, effective discharge),"

"Conferences, allowing them to have a say. Connecting them with resources,"

"I usually work in PICU, and am not that familiar with treatment and discharge planning. I am aware of groups that are offered to patients which is mandatory for their treatment,"

Nurse Practitioners also agreed the Unit advocates for patient centered care via discussions with the staff and asking patients how they would like to be part of their care:

"Approaching staff to inform team that they would like to be part of their care,"

"Discussion. Why, better outcomes. Decrease revolving door,"

The Patient Care Manager stated patients are being involved upon admission during which a care plan is developed and discussed with the patient and interdisciplinary team:

"Discharge planning is discussed with interdisciplinary team and patient on admission. Plan of care is developed creating the care plan. It is important to involve the patient as this is their care, not the teams,"

Question: Can patients become part of the interprofessional team, and why?

Registered Nurses agreed patients can become part of the team. Their responses were:

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"Absolutely. If they aren't part of the decision-making team, they won't understand what the ultimate goal for them is. They can better reach their goals if they are on board with the decisions (or at least they understand why things are being done),"

"They are present at case conference and meet during week as well with collaborative team members,"

"Yes by being involved in their care,"

"They must be. Only the clients know what their goals are. We are not here for what we feel is the client goals. Clients must dictate goals, needs and level of functioning. I always see clients in this team,"

*"*I don't think it is done formally, at present. I believe there is a plan being implemented to include the patient,"

*"*Yes it is great to involve them in their care to provide a more realistic outcome for them, although some patients may not be able to participate based on competency (i.e. form 33),"

There was one exception of a Registered Nurse who stated patients are not professionals and cannot be treated as members of the team, but only as clients receiving care:

"Patients are not part of the interprofessional team because they are not considered professionals from the health prospective; however they are the client, at the center of care."

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Nurse Practitioners agreed patients can become part of the IP team and are "expert" in their care. Although limitations exist based on the severity of the mental illness, a change in treatment plans by including patients can be effective.

"Yes as patients should be involved in their care,"

"Yes, they are part of the team and likely the expert in their care. Although with certain disorders this may precipitate ineffective coping, sometimes change is the best way to treatment,"

The Patient Care Manager confirmed patients are part of the IP team and need to be involved as they are most aware of their own health issues, thus must be allowed to utilize as well as develop new coping skills and strategies to recover:

"A patient is a part of the interprofessional team as the patient is the person to identify current and past issues (if unresolved) that still require a plan of care to decrease negative symptoms and allow a patient to team and utilize new coping skills/strategies."

4.2.3 Professionals' questionnaire responses categorized by CPAT domains.

Respondents were asked to read various statements (S) and rate their answers on a scale of one to seven, ranging from the lowest value of strongly disagree, to the highest value of strongly agree. Out of the eleven responses to the modified questionnaires received, all statements were rated except statements three and fourteen which were answered by ten and nine respondents, respectively. The statements used in the modified questionnaire were categorized under specific domains of the CPAT to assess the views

of healthcare and social care professionals (see questionnaire in Appendix D). Each domain is presented in a table below, which summarizes responses to the corresponding statements. The seven-point scale used for rating responses is: **1. strongly disagree, 2. mostly disagree, 3. somewhat disagree, 4. neither agree/disagree, 5. somewhat agree, 6. mostly agree, and 7. strongly agree.**

Table 4-5: Responses based on mission, meaningful purpose and goals of IPC, N=11

S	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
1	0	0	4	0	1	5	1	11
2	2	0	1	0	2	6	0	11
3	1	1	0	2	3	1	2	10
4	0	0	3	1	2	5	0	11

The majority of respondents indicated that they somewhat, mostly or strongly agreed their IP team members had a solid understanding of patient care plans and are committed to collaborative practice. While the Patient Care Manager mostly agreed, two Nurse Practitioners however somewhat disagreed team members were committed to collaborative practice, and somewhat disagreed there was a real desire to work collaboratively among the IP team. Six respondents, which included Registered Nurses and the Nurse Manager, agreed their patient care plans incorporated best practice guidelines from multiple professions.

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Table 4-6: Responses to determine general relationships among the IP team, N=11

S	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
5	0	0	0	2	6	3	0	11

Nine respondents agreed team members respected each other's role and expertise within the IP team. Two respondents, which were Nurse Practitioners, neither agreed nor disagreed with this statement.

Table 4-7: Responses to determine team leadership within the IP team, N=11

S	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
6	5	1	0	4	1	0	0	11

The majority of respondents agreed their team leader was aware of the team members' concerns and perceptions. Four respondents did not agree nor disagree, two of which were Nurse Practitioners. Only one respondent who was a Registered Nurse somewhat agreed the team leader was out of touch with members in the IP team

Table 4-8: Responses to determine general role responsibilities and autonomy amongst the IP team, N=11

S	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
7	2	1	2	1	3	2	0	11
8	1	1	1	0	4	3	1	11
9	0	0	2	0	1	3	5	11

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10	0	0	0	1	3	5	2	11

Ten respondents agreed team members felt comfortable advocating for patients at the Mental Health Unit, and nine agree everyone was held accountable for their work in the team. Eight of the respondents agreed physicians usually asked other team members for their opinions about patient care, and the remainder of respondents consisting of one Nurse Practitioner and two Registered Nurses disagreed with that statement. Five of the respondents agreed team members were able to negotiate their role in developing and implementing patient care plans, while the other five disagreed.

Table 4-9: Responses to determine extent of communication and information exchange in the IP team, N=11

S	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**N**
11	2	1	1	3	0	3	1	11
12	2	2	1	2	1	3	0	11
13	3	3	0	0	3	1	1	11

Four respondents disagreed that patient concerns were being addressed effectively through IP team discussions. Five respondents disagreed communication strategies were effective when sharing patient treatment goals. Six respondents disagreed their team meetings provide an open, comfortable and safe place to discuss concerns.

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Table 4-10: Responses to determine extent of coordination of care and use of community linkages at the Mental Health Unit, N=11

S	1	2	3	4	5	6	7	N
14	1	2	0	2	1	2	1	9
16	0	0	0	0	1	5	5	11
17	0	2	1	0	2	3	3	11
18	0	0	0	2	0	4	5	11

Everyone agreed their team had a process to optimize coordination of patient care with the community service agencies, and eight agreed the team shared information about community resources. Four respondents agreed patients were able to see multiple professionals in a single visit. Nine respondents agreed the IP team had established partnerships with community organizations to support better patient outcomes.

Table 4-11: Responses to whether physicians are recognized as decision makers in the IP team, N=11

S	1	2	3	4	5	6	7	N
15	0	0	0	0	1	5	5	11

All respondents agreed physicians within the team made the final decisions in patient care, five of which strongly agreed with this statement.

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Table 4-12: Responses to determine extent of patient involvement with the IP team, N=11

S	1	2	3	4	5	6	7	N
19	1	0	0	2	4	3	1	11
20	0	0	0	0	3	5	3)	11
21	0	0	0	0	0	2	9	11
22	0	2	0	2	3	1	3	11
23	0	0	0	1	2	4	4	11

All respondents agreed patients met face to face with team members caring for them, and eight respondents agreed IP team members encouraged patients to be active in care decisions. All respondents agreed IP team members shared healthcare relevant information with the patients. Ten respondents agreed patients and their families were included in care planning, and seven respondents agreed patients are considered members of the IP team. Two respondents however, which consisted of Registered Nurses, mostly disagreed that patients were members of the IP team.

4.3 Qualitative Results

4.3.1 Contextual participant observations.

The PI has attended two daily IP team meetings, both of which involved the mental health team. The first morning meeting took place at 8:30 am at the Emergency Department, and involved social workers, registered nurses, a physician, community partners from Durham Mental Health Association (DMHA) and Canadian Mental Health

Association (CMHA) as well as the Patient Care Manager of the Mental Health Unit. This meeting mainly took place to update the IP team at EMERG with vacancy at the Mental Health Unit, number of beds currently occupied, as well as any potential discharges planned thereby creating vacancy for new admissions seen by the EMERG team. The second IPC meeting took place at the Mental Health Unit at 8:50 am, and involved the same staff aforementioned as well as the remaining group of registered nurses and the mental health team members. This meeting involved discussion of each inpatient conditions, treatments and subsequent discharge plans. The Patient Care Specialist or Patient Care Manager led this IP meeting, and communicated all patient cases to be admitted into the Mental Health Unit as discussed at the previous 8:30 am team meeting. The PI then created a standard matrix (Table 4-13) which was based on the format of the interprofessional team meetings. The matrix included notes on Discharge Focus, Length of Stay, Patient/Family Involvement, Community Partner Involvement, and Physician Present (Appendix G).

Table 4-13: Observation Chart from Daily IP Meetings at the Mental Health Unit.

(Please see Appendix G for full and detailed overview of chart)

	Physician present	**Community partner involvement**	**Discharge focus**	**Open communication**	**Patient/family involvement**	**Length of Stay**
1	Y	Y	Y	No- doctor didn't want to	-	Y

				discharge a patient that the team believed was ready		

4.3.1.1 Physician presence.

A physician was present in four of the seventeen IPC meetings observed. On Day Seven, there was an apparent need for physicians to attend to confirm patient treatments, communicate patient progress and finalize discharge plans. On Day Eight however, the physician that attended was knowledgeable and well aware of the patient's situations. The team was frustrated due to the absence of physicians mostly, and discharge plans were delayed as a result of not having updates on patients' illnesses. The Charge Physician came to the IP meeting on Day Fourteen, and said "it is clear they are not here to communicate about their patients at the IP meeting and we can't update chart." The Patient Care Manager and Patient Care Specialist worked as team leaders taking turns in leading each of the seventeen IP meetings. They communicated information about new admissions from the Emergency Department to the rest of the IP team, as well as led discussions about each patient on the Daily Chart posted at the Mental Health Unit (Appendix B).

4.3.1.2 Community partner engagement.

A full group of community partners were present in sixteen out of the seventeen meetings. This included social workers, case managers, and mental health and addiction

counselors. On Day Three, the meeting was described by the PI as "More efficient, much more patient focussed. Individuals were volunteering to look after patient, update patient information and talk to the patients". The PI also wrote: "the initiative-driven and patient-centered meeting clearly displayed by a community partner saying he will check with patient x to see if they're aware of meeting with the doctor and their follow-up appointment scheduled." On Day Nine, the PI noted the IP team had discussions of community support availability and referrals in place for their patients (Appendix B).

4.3.1.3 Communication.

Discussions in every meeting included reviewing each patient's medical diagnosis, whether patient was medically cleared to go, length of stay, bed availability and new admissions from the Emergency Department, and potential discharges at the Mental Health Unit. Evidence of open and comfortable communication was observed in most meetings. For example on Day Three, the PI wrote: "everyone contributed to the discussion and that there were open and comfortable discussions about treatment and patient cases." On Day Five, community members and social workers had open discussion of options for patients." On Day Six, the PI recorded an example of an informative interaction between the team; however, on some days there were disagreements between physicians and the IP team with regards to patient discharges. On Day Eleven, the PI noted another disagreement between the physician and IP team (Appendix B). It is important to note that as previously mentioned, a physician was present in only four out of the seventeen meetings observed. At times, there was a different dynamic observed with the openness of communication and types of discussions

taking place when the presence of a physician was factored in. On Day One, the PI noted in her observations that communication was more open after the physician left the meeting, during which the registered nurses and social worker were discussing why the "doctor wants to keep a patient they believed can be discharged." On Day Fourteen, a physician entered the IP room, but did not participate in the meeting, such that he was involved in a separate discussion with someone who seemed to be a medical student. However, the Charge Physician joined the IP meeting shortly after and was well aware of the patient's story and diagnosis. In clear disappointment, the Charge Physician criticized another doctor saying he "clearly did not communicate with the team and did not update the patient's chart." The Charge Physician was also present on Day Thirteen, in which he encouraged open communication and asked everyone on the IP team how they felt about discharging the patient. The discussion included the patient's reaction to medication, medical history with previous physicians, and how well the patient spent his weekend pass. On Day Eight, the physician came in late to the IP meeting. However, the PI described him as cooperative and knowledgeable, as he referred to the patient's board and discussed treatment and discharge options with the rest of the IP team.

4.3.1.4 Discharge focus.

Daily IP meeting were organized around discharge planning, and there was not enough focus on patient education of treatment and recognition of patient goals. On Day Five, the Patient Care Specialist stated there "was pressure to discharge and decrease length of stay." On day seven, an IP team member suggested discharges were always planned by physicians on Fridays which created an overload especially at the end of the

work week. On Day Sixteen, the Patient Care Specialist asked "is the patient due for discharge?", and the Nurse said about another patient "I need to follow-up today for discharge" with community partner referral placed. On Day Eleven, the team was frustrated because they had six new admissions from Emergency but could not provide access because the physician was absent and discharge decisions were not finalized. On Day Seventeen, the Patient Care Specialist asked the IP team at the beginning of the meeting "do you have any anticipated discharges today?"

4.3.1.5 Family/patient involvement.

There were often discussions about inpatient transfers to outpatient facilities and the patient's responsiveness to treatment. For example on Day Two, Patient Care Specialist seemed to really know the patient and open communication was observed between him and the registered nurses. Talks of the patient and involving his mother were also mentioned in the PI's notes. On Day Nine, the PI documented the Patient Care Specialist's discussion about a patient with a young son and his genuine concerns with who had contacted the son and who was looking after him.

4.3.1.6 Length of stay.

Length of stay for each patient was discussed in every meeting. On Day Five, there were discussions around availability of beds. On day seven, a patient was at the Unit for thirteen days and "was supposed to have gone yesterday" as one of the Registered Nurses described. On Day Eleven, the PI wrote: "Patient D has been here for 51 days, and still has no plan set because the doctor missed the meeting and when the

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Nurse Manager spoke to him, the doctor said "oh just do whichever plan you think works." On Day Thirteen, there was a patient who stayed at the Unit for 44 days and was due for discharge after having a weekend pass and settled with medications. On Day Fourteen, the physician and the team discussed a patient who was not happy with his discharge, the physician said: "the patient has a place to stay on his own, he cannot wait here 1-2 years until he gets housing". On Day Seventeen, the team discussed a patient who was at the Unit for forty days, but having a fight with her husband was not a reason to stay.

4.3.2 Professionals interviews.

Encoded list of professionals (p) who participated in the semi-structured interviews:

Table 4-14: Encoded list of professionals (p) who participated in the semi-structured interviews

Interview number	P# coded	Title
1	7	CHARGE PHYSICIAN
2	9	NURSE MANAGER
3	15	NURSE PRACTITIONER
4	18	SOCIAL WORKER
5	1	REGISTERED NURSE
6	8	REGISTERED NURSE
7	11	CHARGE NURSE

8	22	REGISTERED NURSE
9	20	NURSE PRACTITIONER
10	25	SOCIAL WORKER

4.3.2.1 Collaborative team leadership.

Collaborative team leadership refers to how practitioners work together with all participants, including patients and their families to formulate, implement and evaluate care services, and enhance health outcomes (CIHC, 2010). This type of collaboration was described in the interview with the Charge Physician, as he acknowledged the role of Registered Nurses as the forefront of care and described them as "representatives of IPC". He explained that physicians however make the final decisions for patient prescriptions and discharge proceeds. Similarly, the Social Worker agreed that doctors make the final decisions with prescriptions and discharge. She also explained that psychiatrists have too much power and missing IP meetings cause delays with discharge plans. A Nurse Practitioner further added that she feels frustrated and not in control when the team and doctors fail to work together towards a unified decision. A second Social Worker interviewed further confirmed that the physicians are the ultimate decision makers when discharging patients. A Registered Nurse explained the physicians' input is necessary during morning IPC meetings at the Unit including communicating discharge plans and length of stay. At times, physicians make sudden discharge plans after meeting with the patients, and inform the registered nurses afterwards.

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4.3.2.2 Interprofessional communication.

Interprofessional communication refers to how practitioners from different professions communicate with each other in a collaborative and responsive manner (CIHC, 2012). The Charge Physician stated there was constant communication between physicians and registered nurses via the Meditech computer software system in which patient notes are entered. Communication between the IP team extends to community members collaborating as the Charge Physician described as "official collaboration and unofficial collaboration with the constant review of patient notes". One Social Worker explained that psychiatrists should be mandated to attend IP meetings daily to promote effective communication and eliminate individual meetings with psychiatrists. Social workers and the IP team always communicate with each other, as the Social Worker described. Communicating with patients is lacking however. The Social Worker stressed the need to educate patients about the resources available to support their recovery. Sharing of patient information with family members is not always an option based on patient's competency and due to the fear of breaching privacy. The Patient Care Manager also stressed the importance of good communication skills especially when patients are often not forthcoming with psychiatrists and registered nurses about their medical state. The Patient Care Manager added that at times it was difficult for psychiatrists to treat patients with addiction disorders, and that was "a learning curve" such that "physicians will not treat or have a difficult time treating people with addiction disorders in the mental health." One Social Worker explained the need to prioritize her conversations and cut them short with patients due to the high work load, while another stated "the meetings no longer include patients and a full interprofessional team". A Registered Nurse described

communication in meetings mainly focussed on discharge planning and not educating patients, and another one mentioned there was a breakdown in communication between physicians and the IP team. A Registered Nurse explained it was important to have physicians communicate patient information with the IP team during their meetings.

4.3.2.3 Role clarification.

Role clarification refers to how practitioners understand their own role and the roles of those in other professions, to establish and meet patient, client, family and community goals (CIHC, 2010). The Nurse Practitioner described one of the roles of social workers and at times community partners was to run group therapies to ensure patients were educated of the community resources available. The Patient Care Manager stated that the absence of geriatricians and social workers can affect the accuracy of patient assessments as she mentioned the "elderly do not have complete assessments, physicians don't necessarily differentiate between deleterious versus psychotic symptoms". One of the Social Workers described their role involved communicating with everyone on the IP team as well as patients and their families, to assess patients and provide them with necessary resources to recover. The Social Worker added they also had a role in discharge planning and transition management.

The Patient Care Specialist suggested physicians need to be better educated in mental health. Many of them generate unnecessary referrals to psychiatrists, thereby adding to hospital waitlists and wait times for mental health conditions that could have been managed initially by their physician. The Charge Nurse acknowledged psychiatrists run busy schedules however still need to provide their IP team with patient updates. A

Patient involvement in IPC

Nurse Practitioner explained the role of patients as clients and not members of the IP team.

4.3.2.4 Patient-centered care and patient involvement.

Patient-centered care refers to how practitioners integrate and value the engagement of patients, their families and the community as partners in designing and implementing care/services (CIHC, 2010). A Registered Nurse explained patient families must be involved and actively included in the patient care process. The Social Worker also stated the patient's family needs to be involved with professionals in planning the care. The Charge Physician added that there was a gap in involving patients, and patients unless deemed incompetent by the IP team, have the right to consent to treatment and participate in the process. He further described patients' interactions with the team are complex. The Charge Physician also explained community partners have a major role in supporting patient-centered practice as they follow-up with treatment and discharge plans as well as financial and housing needs. The Social Worker described the process of collaboration between the team and the community to include the patient and ensure their needs and goals are met. Another Social Worker stated patients must be offered options as part of their medical assessments. The Patient Care Manager agreed patients were part of the IP team and must be involved. She also added that patients were not always happy about being discharged and were often looking for quick solutions to treat their mental health condition. The Patient Care Manager stressed the importance of patient transparency with drug use. She and the Charge Nurse each confirmed the extent to which patient are involved in their care depended on their cognitive function and willingness to participate in

treatment. A Registered Nurse reported that some patients refused to participate in setting goals and treatment plans and that they were not consistently involved in the IP team meetings. She confirmed however the importance to gain patients' input as part of their treatment plan. A Social Worker explained there was a heavier emphasis on the medical model and that conversations with her patients had to be minimized due to the high workload, short staffing, and degree of busyness. She further added it was disappointing to patients that some group therapies were cancelled due to the shortage in social workers at the hospital. Moreover, a Registered Nurse described the inpatient experience as dynamic and hence a holistic approach was needed to deliver care. The Nurse further expressed that giving patients control of their treatment and validating their feelings could enhance their willingness to collaborate with treatment plans. Another Registered Nurse stated patient involvement was necessary for full recovery and decreasing readmission rates to the hospital. She added their involvement depended on their diagnosis, and having a community that equipped them with resources being available to patients.

4.3.2.5 IP team functioning and understanding of IPC.

Team functioning refers to how health and social care practitioners understand the principles of team dynamics to facilitate effective IP team collaboration (CIHC, 2010). When the Charge Physician was of his understanding of IPC, and he answered that it was not necessarily evidence based, and depended on the use of tools as well as working with the patient, provided their mental illness state allowed. He described IPC as working using different degrees of collaboration between registered nurses, doctors and social workers when time permitted. There was "official and unofficial collaboration between

doctors and registered nurses with the constant review of patient care notes", as well as input from community partners. The Charge Physician also expected that IPC "should deliver most comprehensive treatment plans and after care plan, plan after discharge: financial need of patient, coverage for medication, housing of patient, professional follow-up through psychiatry (medical) and psychosocial follow-up" by community partners. The Social Worker believed IPC "is a team working towards the goals of the patient, including the care plan, patient needs, and discharge planning of the patient. So it takes every member of the team, has a role to play in providing a holistic approach to the treatment of the patient." She also added that the "biggest hurdle to effective patient care" is the absence of psychiatrists' input in daily IP meetings at the Mental Health Unit. The Patient Care Manager further stated that there would be no improvements in the team dynamics and how they function "until doctors are held accountable" to attending these meetings and helping finalize discharge plans.

The Patient Care Manager understood IPC as the "collaboration between numerous disciplines" and "is a general collaboration" between these team members that come up with a plan of care with the patient." Her expectations of IPC also included having all the necessary professional disciplines at the hospital, including an Occupational Therapist and Psychologist, to "get a better understanding of where the cognitive functioning is for each individual client," and "diagnose people correctly." The Nurse Practitioner understood IPC as the collaboration between different team members and the community partners. She expected that all team members work together to make patient care better, and found it frustrating when physicians disagree with the team's decision. The Social Worker believed IPC followed a more holistic approach in contrast with the medical model previously used

by physicians. Due to financial constraints and staff shortages, full group meetings were no longer possible on daily basis. She also added getting a Recreational Therapist, Psychologist and Occupational Therapist could provide more "adequate treatment and care" to patients and "can give more comprehensive care, help people get stabilized better, so that when they do get discharged they're not coming back in three days, or a day, or three weeks."

4.3.2.6 Interprofessional conflict resolution.

Interprofessional conflict resolution refers to how practitioners actively engage self and others, including the patient/client/ family, in dealing effectively with interprofessional conflict (CIHC, 2010).

4.3.2.6.1 Transitions pre- and post-discharge.

With the aim for decreasing length of stay for patients at the Mental Health Unit, a Social Worker questioned the effectiveness of their system. She stated there was ineffectiveness in discharge planning which created a "revolving door" of patients returning to the clinic post discharge. The Charge Physician also mentioned there was a lack of comprehensive treatment plans post-discharge including community housing and financial support to patients. The Patient Care Manager described the revolving door as a result of patients not accepting treatments well and failure to deal with their issues. She also attributed the issue of mental health stigma to being one of the reasons why patients do not accept treatments, and another being the length of stay that is too short for patient with mental illnesses to recover. The Nurse Practitioner stated patients do not accept treatments

if they are not involved, which contributes to an increase in likelihood for readmission. The Social Worker commented a conflict she perceived was length of wait time with patients staying in the clinic while waiting for an ECT treatment and the insufficient use of community resources available. Another Social Worker commented social worker shortage was a recurring problem in the clinic such that patients often look for group therapies that can no longer be offered. She added that decreasing the length of stay contributes to the revolving door of returning patients to the clinic. She stated there was a need to make care "more comprehensive and understanding that the real objective should be to stop the revolving door". She also agreed there was pressure to discharge, and the process was disorganized at times. The Social Worker further added she understood psychiatrists were under similar pressures and perhaps cannot attend morning IP meetings due to their busy schedule. The Charge Nurse described discharge as chaotic at the clinic. A Registered Nurse stated daily meetings were focused on discharge planning and not patient goals. She explained: "Where's that patient today? How are they? Do they have knowledge of meds? Have they been taught about their meds? How're their coping skills? Have they been going to groups? None of those things are talked about. Just discharge." The Registered Nurse continued patients living with mental illness need a holistic approach of care as "patients are very dynamic, changing, the needs change quickly."

*4.3.2.6.2 Decision-making and conflict resolution***.**

There is an apparent need to improve communication between physician and registered nurses responsible for executing discharge plan. The Charge Physician also indicated there is a lack of communication and perhaps a time management issue for

decision-making with treatments between the social workers group, the physicians and registered nurses. The Social Worker stated there was a huge issue with privacy when attempting to collect information from patients and their families which she felt was essential to "put together the pieces of the puzzle" for the patient's treatment. She also stated there was a need for an Occupational Therapist that can assess elderly problems, their treatments and safety more specifically. She further commented on issues of treating the elderly were not commonly addressed even at other treatment areas: "But also on the medical floors a lot of people are depressed because they have terminal illnesses, the elderly there, they fall, they have bruises. They're not as mobile so they're depressed. But that piece is very seldom addressed. Once in a while you know they have a consult, a psych consult of some sort right. But again it goes both ways because we see more in mental health, we see more and more elderly people. And why is that, end of life issues, empty nest issues, financial issues, retirement, right? You find partner, um loss of a partner, somebody is dead, right? They can't cope."

The Social Worker also discussed the issue of patient education and having patients not familiar with resources and different treatment options. She stated those options could be a physiotherapist, an occupational therapist, and a recreational therapist which she believed "mental health needs badly".

The Patient Care Manager suggested a recurring issue was educating physicians in the community about mild symptoms of mental health to improve the referral process and thus wait times. She also commented on the clinic's current structure of the Day Program as lacking as patients sometimes are left with a "full day of I got nothing to do." The Patient

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Care Manager discussed the issue of accountability with unregulated professionals such as security guards and Personal Support Workers such that they do not report to the Managers at the clinic. She was not impressed with having extreme cases of patients with mental illness issues assigned to unregulated professionals as opposed to a one-on-one nurse from a registered professional background, yet still holding the Managers and clinic accountable for the type of care being delivered. She stressed the importance of having one-on-one registered nurses to care for patients when constant observation was needed because they are a risk to self, a risk to others, or unable to care for themselves, since the Security Guard often ends up calling the Registered Nurses for help with these patients.

The focus on medication came up as one of the recurring conflicts, as the Patient Care Manager described "our actual mandate, medicate and stabilize and out the door." The Patient Care Manager also commented there was a lack of transition between services to young patients and when they turn nineteen and become adults. She explained young adults should be made aware of their choice to be involved with nursing and medication as opposed to just social work and family involvement when they were children. She added further about the difficulty in bringing an elderly to the Mental Health Unit which includes psychotic patients who display signs of instability and violence due to their conditions, and unintentionally threaten their safety. A solution she suggested was creating an additional unit with geriatricians, Geriatric Emergency Management (GEM) nurse, and a team tailored to providing more specific care to patients of the elderly population and living with mental health issues.

Patient involvement in IPC

A Registered Nurse described the work of the IP team as "very poor" and "disjointed" on the fast paced floor on which they worked. The Charge Nurse explained the decision to include patients in an IP team meeting to discuss treatment plans depends on their mental diagnosis and ability to cope. She further added it had been difficult to hold goal-setting groups because registered nurses are not necessarily qualified to run a specific therapy group. She explained it was essential to consider consistency with who runs groups with patients regardless of how successful the group turns out. She suggested to have more than one nurse to run groups if necessary, to be able to handle any potential crises within a large group of patients.

4.3.2.7 Expectations.

The Charge Physician expects that IPC should help "deliver most comprehensive treatment plans and after care plan, and plan after discharge". This includes looking after the financial needs of patients, coverage for medication, housing of patient, and professional follow-up through psychiatry (medical) and psychosocial follow-up by community partners. He also stated the importance of social services "because patients are poor and lack social support and lack of housing."

The Social Worker says that "psychiatrists should be mandated to attend interdisciplinary team meetings". By doing so, she states this "can eliminate the individual meetings that we have with some of the psychiatrists on a daily basis." The Patient Care Manager stated that many patients leave the Unit unhappy when discharged because they do not understand that sometimes people recover better at home and that the hospital "has never been a hotel". Although it is costly to keep patients in hospitals for full recovery,

she also expects that hospitals determine the length of stay by "looking at each individual person as a person." The Patient Care Manager states that IPC is achievable and "should work with time, education, and resources," and ensuring "every unit should have all necessary disciplines." She explains: "An OT here could run groups, you get a better understanding of where the cognitive functioning is for each individual client. Are they at a high level? Are they at a lower level? What kind of supports do they need? Are they able to manage to do activities of daily living like write a cheque, make dinner, or their wife just died and the man has not got a clue how to pay the bills? How do you do groceries?. Shocking little things like that but what a difference it makes, arts and crafts, they have to have an enjoyment here as well. Though we're short term, there are lots of activities that could be done. A Recreational Therapist, I would love a Recreational Therapist but do not have the money. I would love a psychologist to actually diagnose people correctly."

The Nurse Practitioner clearly stated her expectations were that IPC supports the teamwork process with everyone working together to improve patient care. The Social Worker explained there is a need for more nursing, social work, and OT staff, in order to produce more comprehensive care plans and help patients get stabilized without returning to the clinic shortly after discharge. She stated: "Again it comes from Ministry; it comes from lack of funds, resources, budget, all that kind of stuff. So people are quite devastated a lot of times… when they say can I sit down and talk to you, with the degree of busyness right now I can't."

A Registered Nurse stated her expectations include discussing patient goals during morning meetings instead of majorly focusing on patient discharge. Another Registered

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Nurse expects more professionals to attend the interprofessional team meetings: "I know it is hard to get all that orchestrated. But I think it really works well when you have all the players together … I expect that we all be a part of it, we should all be utilizing it. And everyone has a role to play in it. And when you don't utilize it, I do not think you're always doing the best patient care." The Charge Nurse similarly stated there is a need for more community partner involvement:

"I think we work really well as registered nurses, doctor, social work. Like they try, and community partners obviously too... But even then like ever since they've kinda gone down to EMERG we don't have as many Pinewood services. We do not have as much Durham Mental Health, we have one for part of the day. So sometimes if you have someone going for the afternoon, it's a little difficult."

A Registered Nurse expects registered nurses to be more involved since their opinions and observations can strongly impact care plans. Also, the Nurse Practitioner expressed the need for making psychological counselling more available to benefit patients.

4.3.3 Patients interviews.

Table 4-15 describes the encoded list of patients who participated in the semi-structured interviews:

Table 4-15: Encoded list of patients (pt) who participated in the semi-structured interviews.

PT	Gender	Diagnosis
1	M	Depression and Post Traumatic Stress (PSTD)
2	F	Major Depression
3	M	Major Depression
4	M <30	Bipolar
5	M<30	Drug Induced Psychosis
6	F	Depression and Anxiety
7	F	Bipolar
8	M<30	Bipolar and Depression
9	M<30	Depression
10	M	Depression
11	M<30	Bipolar
12	F <30	Depression

4.3.3.1 Inpatient experience.

4.3.3.1.1 Collaborative leadership.

A patient (PT1) with depression and post-traumatic stress described his psychiatrist as "very good" and said: "I see him every day even if it's only for 5 minutes. It could be 5 minutes to 25 depending on how long I need, like he would stay if I needed to talk. He didn't rush me or anything like that."

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Another patient suffering from depression, PT10, stated "the doctor" told him he was going to be discharged the following day. PT10 stated his experience was "good, it is been peaceful here. Except for the last I guess this morning had a girl who went nuts on the ward and they had to take her out." When the interviewer asked how that made him feel, he answered:

"Ah like I should not be here. Like I wanna get out of here. I have been here since last Thursday, so I'm tired of being in here and I wanna get out to the rest of the world."

The young male patient diagnosed with drug induced psychosis, PT5, stated he had a "strict" experience with "not a lot of lenience". He preferred more room privacy, less breaks with longer timespans, and more food options for the patients.

A young bipolar male, PT4, said the social worker informed him first of the discharge, then the doctor confirmed it, and the registered nurses helped him with planning it.

PT12, a young female who suffers from depression said her psychiatrist helps guide her with medication: "I know that like right now as soon as medication is right, my psychiatrist will guide, like he will let me know what my next step is. He wouldn't leave me just ok you will be like fine, out the door and there you go." She also noted shortage with social workers and was disappointed with reduced number of groups offered: "I found that there was not enough group cause they run the group so if they are sick there is no group. Um I think everyone kinda struggled with that a little bit, cause that goal setting group in the morning is really good. But I think the need to try and fill in all the time with

groups a little bit more, the more groups would be more satisfactory to a lot of the patients I think we would say."

PT8 described care at the clinic as "unconditional" and said people are supportive and that he was "very happy with everyone". He explained: "people have been so good here, say 99.9% of the time, people are very caring and supportive."

PT9, a young male patient with depression acknowledged the significance of communicating with his psychiatrist: "With cutting out the doctor or just going to the nurse, it would just be a temporary solution. Whereas the doctor can actually say ok this is what I feel is happening, and this is what is what we are gonna do." He further explained that doctors are the "true professionals" and "can better diagnose" any of his problems." He was however disappointed that his psychiatrist did not seem to have read his patient notes taken by the nurse: "I do not know where he got that impression that I had a bad weekend cause all my registered nurses said how well I was doing. So I thought that he didn't read any of the notes."

4.3.3.1.2 Readmission within 30 days.

PT1 explained he had been to the clinic six times in 2012 but was his first time this year in April 2013 when the interview took place: "Well this was ah, as bad as it sounds, six times in less than a year; three voluntary three times I was brought in by the police. Last year when I came for the first three or four times, I didn't really know what to expect, I did not really go with the program."

Patient involvement in IPC

PT4 had been admitted to the clinic once within the past 30 days of his stay at the clinic. In the previous admission, he stated that he had stayed for two weeks, was discharged, and then readmitted two days post-discharge. He said: "Just once I stayed for like fourteen days and got discharged. Went home and I had to come back."

The female patient with a bipolar disorder, PT7, was admitted to the clinic once within the past 30 days, then returned two weeks post-discharge. PT12 was admitted to the clinic one time in the past 30 days.

4.3.3.1.3 Length of stay.

The young male who suffered from depression and bipolar disorder, PT8, stated he was at the clinic for two and half weeks.

PT9 stated he had been at the clinic for eighteen days, and was given a weekend pass to attempt setting a date for his discharge provided the pass went well.

PT10 stated he was at the clinic for the first time and had stayed for seven days and his discharge plan was dated the following day as per the psychiatrist's conversation with him.

PT7 had been at the clinic for fourteen days. The female patient with depression and anxiety had been at the clinic for twelve days and not aware of the expected discharge date. The young male with drug-induced psychosis was at the clinic for fifteen days and expected discharge in seven days after discussion with his psychiatrist.

Patient involvement in IPC

PT4 was at the clinic for seven days, and not aware of when his discharge was going to be.

The female patient with major depression, PT2, had stayed at the clinic for 21 days.

PT1 was at the clinic for seventeen days:

"That's why I came in to get some medical, medication stabilization so that I become stable on the meds and have a really good mixture. That's why I've been here for seventeen days it took a couple of tries but we finally found the balance."

He also explained:

"One of the things I really enjoyed out here is that they stress in the moment when you come in, you'll never get to a 100% in the hospital. You can't, you can only get to you know 60-70% and the rest is on you outside of the hospital. And they stress that point to everyone, and I think that really helps people realize I will get as better as I think I will in the hospital, can't get to a 100 percent. You're right I need to figure out a way to get my spirits up and then once my spirits are up, and have got a plan in place, I think you can do the rest outside."

PT12 had been at the clinic for fourteen days, and was expected to be discharged in five days.

Patient involvement in IPC

4.3.3.2 Understanding of IPC.

PT1 answered to the interviewer's question about his understanding of IPC as the following:

"How all the doctors, registered nurses, social workers, hospitalist? I forget what the other registered nurses are called. They come in and basically someone needs a medical problem or you know it's just a psychiatric problem then the nurses can address both and they get certain people to come in and take a look at you. Yea it makes you feel like they are actually doing something for you."

PT2 answered collaborative care should not be about sharing secrets like those in the therapy groups that she disliked. She said:

"It is about creating boundaries, everybody should have secrets and that we should not be sharing secrets. It is a liberating experience."

The male with major depression, PT3, stated IPC is about "people working together. It is teamwork between the psychiatrist and the ah social worker and ah the housing fellow."

When PT4 was asked the same question, he was unaware of this type of care and answered: "Um, I do not really know."

PT5, the young male diagnosed with drug-induced psychosis explained IPC to him meant providing patients with enough food and keeping their lunch rooms clean from garbage. He said:

Patient involvement in IPC

"The fridge needs to be stocked for patients, they are not keeping track of garbage disposal in the lunch room like last night."

The female suffering from depression and anxiety, PT6, explained it was the care she received from registered nurses and psychiatrists.

PT7 stated:

"My understanding is to get you functioning in society, I get like being able to attend to your family. Being able to go back to work. Being able to just function in society. When you're depressed, or when you have bipolar mania, or depression, or schizophrenia and you get that depression inside. You don't get any back, you cannot get your laundry done, your house is not clean. Suppers are not cooked, you don't even eat. And here, they get you, I do not have trouble taking my medication. Some people do, and they get you back taking proper medication. They get you eating properly. I eat worse here that I do at home, cause I cannot stand the food. But my mom gives me money for food. They just help you, and get you back functioning. And when you can function, you can go."

PT8 answered:

"People make a $100,000 or $1,000,000, they should have the same kind of care and support no matter what you do. You can be making ten dollars an hour, people are very greedy these days I am not saying that to be rude."

Patient involvement in IPC

PT9 answered: “I see it as that, it is supposed to be collaboration of everyone together to make one patient as good as possible. Um that is really about it… They cannot fix everything here but they try their best.” He also stated: "the social worker as well as some of the registered nurses try to keep my family in the loop."

When PT10, another male patient with depression, was asked what he understood about the collaborative process, he answered: “not too much.”

PT11, another male patient who was bipolar, initially did not have an understanding of IPC and asked for further clarifications. The interviewer repeated the definition of IPC as per her script: “The process of everyone working together in order to provide you with care. That includes registered nurses, it includes social workers, it includes um patients as well.” The patient was then able to answer stating it was collaboration between patients amongst themselves “listening” to each other. He continued:

“Well I would say about that, that I’m a patient with lots of patients. So I do listen to most people. Sometimes it can be ahh difficult to try and listen to four people at once. Like the doctor, psychologist or psychiatrist, social worker, rights advisor, a lawyer doctor again. You know ah nurses, RPNs, people that are just here as students.”

PT12 explained IPC meant that patients were to help themselves manage their own illness while working with the registered nurses and attending group therapy sessions at the clinic:

Patient involvement in IPC

"I would say it would be um, that you as a patient, you as a patient to work like, you're not just in here to rest. Like you have to work on yourself as much as the nurses have to work on you. Like do you understand, like you cannot lay here in bed and expect to get better… But there are groups that are mandatory that you have to attend, and um I think that's great because you know, you learn how to goal set. You learn how to um, like deal with your anxiety, and you learn you know, you talk about your, the reason why you are here and you expect from being here. And well it's like it should not, there is no just laying here and without dealing with your issues. You have to work, you have to help yourself."

4.3.3.3 IP team functioning.

PT1 noted good communication between himself, the nurse and the psychiatrist when it came to addressing medication effects: "The doctor had the decision to change it or what not, the nurses would also come in after you get the first one at night time. You try it the next day and they come in and say well how do you feel today after taking that last night, and it was good because they pass it along to the doctor." PT1 explained:

"There is a lot of people on this floor I noticed, there is a few of them that have been here for 25, ten years stuff like that. They enjoy it. They enjoy this floor with the nurses; psychiatrists have worked together for so long it's become an enjoyable job, yea familiar place."

PT5 claimed psychiatrists were more professional in their treatment with patients than registered nurses: "Doctors are good. When they ask questions they trick you. Like

doctors are way more professional, may know where your room is but ask about going to a room. “Let us go to that room,” and wait. If you correct him, he will not bug you or anything like that. Nurses are not all as professional like I do not think nurses should come into your room when you’re sleeping or open door completely.” He also said registered nurses were not fully aware of the discharge plans: “Doctor told me what is happening with the discharge plan, I do not think nurses know about the plan. Because so many nurses and should be more informed of each patient, personality of some people who like to be alone or louder, understanding the patient and can specialize the treatment.”

PT8 described the care as being well put together despite the few times he had seen his psychiatrist:

“In general the care is pretty well put together. Um the nurses and social workers work very well together. On the other hand the doctors seem to talk to the doctors rather than the patients. Like in the time I’ve been here I’ve seen my own doctor for maybe a total of 20 minutes. And I have been here for just over two weeks.”

PT9 explained everyone from the IP team, which included the social worker, registered nurses and psychiatrist, were all involved with planning his discharge. He said: "My nurse worked with me to get an appointment set up with my social worker. The doctor spoke to my nurse beforehand about it as well. The nurse came to me and we went from there for the social worker and we had a meeting set up, so everyone was involved in that process."

Patient involvement in IPC

When PT10 was asked how he thought IPC worked, he said: "I don't really know, I just think it's working pretty good."

4.3.3.4 Patient-centered care.

4.3.3.4.1 Expectations.

PT1 formulated his expectations from the previous admissions he experienced at the Clinic, and indicated his expectations were to cooperate equally with the registered nurses and psychiatrist to recover: "So this time around they noticed I have to come in with the expectation of somewhat I guess a 50-50, I had do half and the doctor can help me with the rest. And I came in with that moto in my head, that idea, and ah it really worked."

PT1 went on describing his expectation to work with the psychiatrist and receive medication that can stabilize his mental health illness:

"He was pretty good if I said oh this med you know is actually not working it's getting me more drowsy or it is bringing me down more than it's bringing me up, he is very good on that's why I came in to get some medical, medication stabilization so that I become stable on the meds and have a really good mixture."

PT2 stated that she needed her friends and family, as well as emotional support. She also said: "We should have somebody to come in and talk to you. Compassion heals."

Patient involvement in IPC

PT4 stated: “I wanna get better, I wanna have professionals that understand what it’s like that I’m going through, and I want them to, to help me out with what I’m going through. Get the help that I need.”

PT7 explained her expectations were to achieve recovery that would allow her to live a normal life:

“I expect that I’m going to be able to function for a few years. Years, not months, years. I would not have done this if I didn’t think I get three years out of, and I may not go back to school but I definitely want a job in a grocery store or something. Something, so I can get off ODSB, I don’t wanna be on ODSB anymore. I wanna have a family, you know and I want them to be able to give me that. To give me medication that’s gonna help me, not not help me anymore.”

PT9 said he expected everyone in the clinic to collaborate and meet the patient needs, and that collaboration would stem from the psychiatrists down to the registered nurses to communicate the plan to patients. He explained: "I expect for everyone in the facility to work to the best to the needs of each individual patient. I expect the collaboration to go from the top to the bottom. So from the doctors down to the patients, of every detail being described no matter which person it’s coming from. As long as the doctors speak to the nurse, and if the nurse comes to the patient and says this is what’s going on, then I see that as beneficial to everybody."

When PT10 was asked what his expectations from IPC were, he answered: "just that I expect to be better than I was before I came in."

Patient involvement in IPC

PT12 wished the social workers kept patients more informed of the community resources available: “Like keeping me informed I guess of what is out there in the community for help.”

4.3.3.5 Interprofessional communication.

4.3.3.5.1 Patient relationship with psychiatrists and registered nurses.

PT1 described communication between the registered nurses and psychiatrists as quick:

“All the doctors have a message board and they put it on there so when the doctor first comes in he can go at it, like he already knows what he’s coming in to which is good because then it doesn’t really make me have to explain it too much to him.”

He was comfortable in his communication with the registered nurses: “I came in at first I was very ah I guess, not as social I would say as today, and the registered nurses really helped me with that they’ve taken me to group and let me know hey you do not have to come out but coming out will make you feel better so I started to come out slowly, they really brought my mood up after.” He continued: “They are usually pretty good at the communication with each other. So it does work very well because they seem to have it on a good plan.”

PT5 however felt that communication was forced between registered nurses and patients, and that psychiatrists should meet with patients more often: “A lady fell asleep for five minutes, but had to repeat herself million times but forced her to go on wheelchair

back to her room and paint. So there's a gap in communication. Doctor should be in more often and get help better."

PT6 explained although she saw her psychiatrist every day, communication was lacking:

"My doctor I feel, he sees me every day, but then he asks me a question, there is no eye contact. He's writing and writing and writing, and just as I start opening up to him he is gone. I get three to five minutes with him."

She also claimed her good and bad days depended on which nurse was taking care of her: "I have my good and my bad days. It depends I guess on what nurses are taking care of me each day. I have a few nurses that I feel more comfortable putting up with, where they seem more sympathetic to why I am in here and are able to talk me through it if they notice more of my behavior… Whereas I have other nurses that just come over and give me my pills."

PT7 said the registered nurses were helpful especially with the families, however she wished that they would be more informative and provide patients with resources such as social workers. She explained that she had to ask for an appointment because she was not previously aware of "what they could do" for her.

PT9 stated his healing process was improved with the help of the registered nurses: "The nurses here are very involved. There are a couple nurses here that will go completely out of their way and try and help you in any way possible. Like for instance, when I started here I lost my privileges to go outside and I was put on something they call a

form. So I did not have any rights, basically I was just present in here. I had the help of the nurses that helped me so I could go off it, so I'm able to go outside and get fresh air and have a cigarette, have a better healing process."

However, PT9 felt psychiatrists did not often follow-up with the registered nurses' patient notes documenting incidents at the clinic and updates on patient recovery process; however they are improving in reading the notes. He said: "I felt that he (psychiatrist) just assumed that it was a situation I would have had a bad time with it. But since then he has been a lot better, I feel he has been reviewing the notes now, and honestly I just think he assumed that I was not going to handle the situation properly."

PT9 said he wished to see his psychiatrist more but also acknowledged psychiatrists were busy: "Honestly, I wish I would see my doctor more. But I feel like the registered nurses and social workers make up for it… So all in all, the care is good, just ah the doctors should be little more involved with the patients. I know they are busy so that is why they do not have much time and that's why they are relying on nurses and social workers… But they always get over when you have to see them."

PT12 said the registered nurses talked to her on a daily basis, which she found caring and helpful: "The nurses really care, umm I find that they always come in and introduce themselves before their shift is started. And then there is always a time period where you can sit down if you have any issues to talk to them about, or they'll come in and ask us how's your day going, you know let us talk about whatever is bothering you. They have time for that which is great because being a patient with mental illness you need somebody to actually talk to you on a daily basis about how you are, how you are doing."

Patient involvement in IPC

PT12 said her psychiatrist paid attention and listened well to his patients:

"Well the one psychiatrist is awesome, I can't remember his name, he is really funny… Like my psychiatrist has visited me like a lot. He is really listening, and he is really paid attention to his patients, right. You know and he really can tell like my experience, he can really tell if you are ready to move to the next step."

4.3.3.5.2 Patient relationship with social workers.

PT1 indicated a good relationship with the social worker: "yea there is a social worker, I'm pretty close with the one, we talked."

PT2 described her communication with the social worker as the following: "The social worker connects you to housing, talk therapy like a friend, I'm here for you, how do you lift off this problem."

PT4 had good communication with the social worker. He said: "I have social workers to talk to, mine are. When I need to get something straightened out about my life."

PT6 was felt disconnected with her social worker: "The social worker I have seen her one, twice. One that was a few minutes in her office and "it was just pamphlets that were given to me about programs and who I can speak to. It was not much of a talk of my problems or anything; it was just all about what programs can be offered to me. And then on Tuesday, she wanted a meeting with my husband and her in her room. And again it was for him to find out what was going on, and what meds I'm on. How long am I gonna be on them. I just want somebody to understand and say I understand where you're coming from

and these are steps we are gonna take it from. But I just do not feel like I am getting that from her."

PT7 on the contrary "I thought they are very informative." She continued: "I thought they knew how to help me when I didn't understand what I needed from them. You know they were able to um, lead the conversation and offer things that I did not know was out there. And they do not have to do that."

PT9 felt social workers were "excellent" and said care was good overall: "The social workers spend as much time as they can, and they try and to keep you in the loop with everything that is going on. Especially the one social worker here is excellent."

PT11 stated social workers were very busy and it was difficult to meet with them: "The social workers they're busier sometimes than the RN's so to see a social worker it is difficult."

PT12 did not find the social worker helpful. She stated: "I did not get the feeling of caring, from the social worker I have. It is more of here is the information I hope you do well see you later. What she did was she, gave me these papers which made no sense to me whatsoever."

4.3.3.5.3 Education and group therapies.

PT1 gave feedback of the different types of group therapies available to patients: "A lot of the patients did mind, stress and anxiety group which is ah basically we go in and we do a conversation about any stressors or how to deal with stress and anxiety. But I think

people did not really open up to it as much because the doctor always would say a set conversation, like so well what do you guys wanna talk about today, and then let us sit… That group is ok, but the hope group is only once a week, but everyone really enjoyed that group because it is an open floor conversation. Umm so the conversation gets a little intense or hit you emotionally, you can get up at any point and leave and come back. And I found more people opened up to each other or to the whole group. It might even be just to the chaplain so it is a little bit easier than to a nurse or a doctor or you know, something like that. A chaplain, it is a little more empathetic and comfortable."

He also mentioned the social worker's shortage the reason for group therapy cancellations:

"Staff shortage of the social workers and stuff like that with my experience being here the one has been off for two and half weeks or been on holidays, she was sick for a week and off for the holidays for a week. And the other one was sick for a week. I found that there wasn't enough group cause they run the group so if they're sick there is no group."

PT2 stated her experience was "pretty good except it is medication oriented." She also said: "I really like the group meetings and I really like that one said "you guys have to learn how to lie", teaches hypnosis as a form of therapy. So made subconscious say yes and no to a question he had me under. He is a registered MD."

PT3 stated group meetings were only beneficial at times, and not helpful and depressing other times:

Patient involvement in IPC

"Some, sometimes in the morning like did not have any this week cause we are short on staff. But whenever those meetings take place, they are sort of beneficial. Sometimes they just bring you down because someone starts crying her face off. It's depressing for me to sit and watch that."

PT4 stated "and there is groups that are very helpful to attend."

Patients collectively stated there was a greater focus on patient medication however lacking the education of how the medicines work. PT5 stated:

"They should inform patients a lot more of what medication we're receiving and possible side effects or allergies that can make that illness worse. What am I taking and how is it going to help me."

PT6 described that depending on which nurse she got, some registered nurses were less sympathetic and more focussed on giving medication:

"I have other nurses that I feel do not give a crap. You know what I mean, they are here to do their job, give you your pills. Just basically by textbook. And in here I feel, like for me personally that I need one on one for someone to understand me and talk to me. We are all in here for different reasons."

PT6 was unhappy with some group therapies as she believed it invaded patients' privacy and increasing her anxiety:

"I find the group meetings make me uncomfortable, because I do not open up or say anything but I hear other people talking and I feel I'm invading their privacy by that. So I

get up and leave, and like a lot of things they say reflects on something I am going through I do not wanna hear it. It's like a denial thing. And again I get up and leave, I have not been to a lot of group meetings because of it."

She also stated there was a huge focus on medication as opposed to offering someone to listen to her issues:

"Whereas I have other nurses that just come over and give me my pills and here it goes, like you know they have heard it all before kinda thing right, and I understand they are busy and what not, but what I expected coming in here was for someone to listen and understand why I am here deal with it. But I just feel like it is pills more pills and more pills.."

PT6 also felt that psychiatrist did more of the talking than patients:

"I have sat there and one topic one day and sort of asked around the room, where the doctor did more talking and comparing to other patients that he had."

PT8 said the group therapies were "amazing" and continued:

"We have group sessions here which is good. So everyone gets to know us in semi-circle. And I try to help if someone is raising their hand or somebody is talking, I make sure I support them. Cause I have been there, I think I have been through every kind stage of depression."

PT11 explained group therapy sessions were very important:

Patient involvement in IPC

"Groups I think are the most important things."

Patients also mentioned that their expectations include setting more group therapies at the clinic.

"Like I said there was not this time around cause she was sick but the nurse should have filled in. but I think that um, a lot of people are asking for the hope group, or groups like the hope group to be more often. At least once a day, we have people that need time to reflect each day."

"Because so many nurses should be more informed of each patient, personality of some people who like to be alone or louder, understanding the patient and can specialize the treatment."

PT12 appreciated goal setting groups and felt were helpful:

"There are groups that are mandatory that you have to attend, and um I think that's great because you know, you learn how to goal set. You learn how to um, like deal with your anxiety, and you learn you know, you talk about your, the reason why you're here and you expect from being here."

4.3.3.5.4 Treatment plan.

PT7 described the importance of involving her family and getting their support with the treatment plan:

Patient involvement in IPC

“They are (nurses) really trying with my mom. they let me sign papers so that my mom can phone to the nurses station and get any information that she wants from them, like that is bonus cause I feel when you have a mental health illness, then if your family is not important to you and you do not have that support, you are, you are, it is not good. You need it… Like you definitely need family support, like the nurses need to help with the families, and they do here.”

PT9 explained he was getting updates in meetings with his family and the social worker. He further explained:

"The registered nurses will spend individual time with every patient. The social workers spend as much time as they can, and they try and to keep you in the loop with everything that is going on. Especially the one social worker here is excellent. We have ah some very caring nurses that try to get down to the root problems."

PT10 said: "I have got nothing to complain about, actually there has never been."

PT11 found it difficult to listen to everyone when his team meetings include multiple professionals. He said:

“Sometimes it can be ahh difficult to try and listen to four people at once. Like the doctor, psychologist or psychiatrist, social worker, rights advisor, a lawyer doctor again.”

PT12 felt the registered nurses being supported helped with the treatment plan:

Patient involvement in IPC

"You know the treatment here is really really good… and all the nurses that I have been in contact umm that seem to really care. I do not have one incident where I felt like, I felt like ahh I guess maybe I was not supported."

4.3.3.5.5 Discharge plan.

PT1 shared his collaborative experience with the IP team to get discharged:

"I made the plan myself, Saturday I found out about the job out west so I knew I needed some time to get stuff in order and I felt ready come Saturday. So I said to him I wanted a pass next Tuesday make sure I'm ready again. And at the day pass, it went really well, we went and decided I had to meet the social worker on Wednesday and talk to the social worker for a little bit, and today I am out."

PT2 was aware of when she was going to be discharged from the clinic.

"Doctor told me what was happening with the discharge plan, I do not think nurses know about the plan."

PT8 explained that he had requested a discharge but was delayed because his "parents were overprotective." He however mentioned the discharge was planned:

"We had planned, we had a plan. We already had a plan for this"

PT9 was aware of his discharge plan as per his discussions with the psychiatrist; however he did not have a date set:

Patient involvement in IPC

"The doctor told me of the first discharge date, which would've been this, um tomorrow. However after my meeting with the social worker yesterday, she said she was going to speak to the doctor and say what she thought should happen. So at this point I am not sure about the discharge date."

PT10 was aware of his discharge date and said "the doctor told me." He did not share in detail what the plan included and how it came about.

PT11 was aware of his discharge plan as the social worker initially introduced it to him, then the psychiatrist confirmed his discharge at their meeting and the registered nurses helped with the planning. He said:

"I knew I was going to be discharged this week. Yea and the doctor says, the social worker actually was the first person to talk to me."

There were some delays in his discharge however, as he expressed in frustration:

"It's still frustrating when you have a date set for something, or time, and ahh that time is interrupted or it is not properly explained as to why it was interrupted."

PT12 said that her psychiatrist suggested a discharge date depending on how she would be doing:

"Dr. have mentioned that next Tuesday I would be, he would be thinking about discharging me, umm so hopefully that will be possible. But he always asks me first like how, what are you gonna do when you walk out the door."

Patient involvement in IPC

4.3.3.6 Patient involvement and interprofessional conflict resolution.

4.3.3.6.1 Patient accountability.

PT1 said: "One of the things I really enjoyed out here is that they stress in the moment when you come in, you will never get to a 100% in the hospital. You cannot, you can only get to you know 60-70% and the rest is on you outside of the hospital."

PT12 said goal setting groups were helpful because they helped patients realize they too need to work with the IP team to help themselves recover:

"And well it is like it should not, there is no just laying here and without dealing with your issues. You have to work, you have to help yourself."

She continued:

"I think that it is if you are in the hospital you need to work with your professional team to get better! Like again, you cannot just expect them to be sitting in the chair 24 hours a day just watching you."

4.3.3.6.2. Willingness to collaborate and patient transparency.

PT1 expressed frustration with the delay in his discharge:

"I was expecting to be discharged today, but you know they are looking for um a crisis bed so I can go to. So I donno what the hell happened. Later on this afternoon or maybe tomorrow."

Patient involvement in IPC

He understood the importance of collaborating with the IP team to achieve recovery. He said:

"If you work with the nurses they actually can do phenomenal things for the patients, but you just come in and say I am not taking notes I am not doing this I am not doing that. You are gonna be loud, you are gonna be rude, and be mean to patients, they just do not care."

PT6 told the IP team members she did not find group meetings helpful and came up with excuses not to attend:

"I do not go to group meetings.. They are just not for me. I do not have patience… I have told the doctor, I have told my social worker I have told the nurse, I have told everybody that every day I came up with a different excuse why I did not wanna go into the meeting. They called me, I said I had a headache I was tired, because it is not helping me."

PT6 described her discomfort attending group therapies to avoid judgment by other patients: "I do not have anything besides group meetings where I can open up or say anything. I do not want to share everything, I am not proud of a lot of things and I do not want people judging, I feel like people are judging me, and I was not like that before. I feel sometimes when I go in and get some stuff of what the doctor is saying, but then the other people start speaking up and relate topics like personal experiences. And I start getting bothered by that, not that I do not care. It is just that I am afraid to speak what mine are and get it out there and people judging me."

Patient involvement in IPC

PT7 also refused to attend group meetings and said instead, she went to individual counselling.

PT12 said patients need to collaborate with the professionals and explain how they feel to help with the recovery:

"So it is important that you either go to them with your issues or your pain, or whatever you are feeling and you need to let them know because they cannot read your mind. You have to let them know what's going on with you in order for them to help you, or to guide you to the next phase even you know."

4.3.3.6.3 Patient safety.

PT1 commented some patients do not seek treatment because all they need is a safe place to stay:

"I think ah there is some people like I said to you who do not give two scents about getting better or not. They just needed a place to be safe."

PT11 commented the clinic felt safe and compared it to "home":

"And like security here does a great job of monitoring things, the hospital is very safe and clean. You feel like you are at home away from home."

4.4 Conclusion

Challenges to the delivery of patient-centered care originated from excluding patients from the decision-making process. The interviews and observations of IP

meetings rather alluded to a bigger focus on discharge planning and length of stay, and less focus on patient education and involvement in group therapy sessions at the Mental Health Unit. Different dynamics between team members were observed, such that more comfortable and open discussions of patient treatment and discharge plans took place when physicians were present. The Charge Physician acknowledged during one of the IP meetings that some psychiatrists lacked proper communication with the team. Also, the absence of psychiatrists during interprofessional team meetings, shortage of social workers and lack of a diverse interprofessional team created negative patient and provider experiences as presented in their interviews. The concept of shared-decision-making as well as the effect of these factors on patient discharge plans, length of stay, team functioning, as well as the patient and provider experience are further analyzed in the Discussion Chapter Five using non-parametric analysis of the questionnaire results and thematic analysis of the interviews.

CHAPTER 5

Discussion of Findings and Recommendations

The purpose of this study was to document and analyze the experiences of inpatients and healthcare and social care professionals in an interprofessional collaborative mental health setting. The following research questions were used to identify the role of the patients and examine IPC approaches used by professionals to deliver patient-centered care:

I. How does interprofessional collaboration support patient-centered care?

II. To what extent is the patient involved with the IP team?

The National Interprofessional Competency Framework (NICF) identifies six competency domains required for effective interprofessional collaboration. These domains include: I) collaborative leadership, II) interprofessional communication, III) conflict resolution, IV) patient/client/family/community-centered care, V) team functioning, and VI) role clarification (CIHC, 2010). This framework was used to guide the analysis and discussion of the results for this study. Chapter Five discusses the findings of the study in relation to each of the domains. It also presents implications and suggestions for the Mental Health Unit on how to incorporate IPC and involve patient in the care process. The chapter concludes with study contributions and suggestions to further benefit future areas of research.

Patient involvement in IPC

5.1 Collaborative Team Leadership

Collaborative team leadership is the domain in NICF which refers to how practitioners work together with all participants, including patients and their families, to formulate, implement and evaluate care services to enhance health outcomes (CIHC, 2010).

5.1.1 Leadership from the perspective of professionals and patients.

According to Schroder and colleagues (2011), leadership with healthcare professionals is experienced at different levels, and healthcare professionals work on multiple services within one institution with more than one leader. Healthcare professionals choose their leader depending on the context and situations (CIHC, 2010). Physicians traditionally make decisions with regards to discharge, as they are ultimately responsible from a medical-legal perspective (Lahey & Currie, 2005). On the other hand, Macleod (2006) and Day and colleagues (2009) suggest that registered nurses should also be proactive leaders in discharge planning. Registered Nurses are believed to have the most updated information about the patient's state and wellbeing as they spend the most time interacting with them and their families (Macleod). Similar to these findings in the literature, this study presents situations in which Psychiatrists and Nurses assume the role of leaders in the collaborative mental health setting.

The essential role of registered nurses as leaders is confirmed by the Psychiatrist and Charge Nurse interviews, in which nurses are described as the "forefront of care and representatives of IPC." During the interviews and observations of IP meetings,

professionals complained patient wait times were higher as some patients were not ready to be discharged without their Psychiatrist's input. There were two nurse leaders, the Patient Care Specialist and the Patient Care Manager who took turns to lead the interprofessional (IP) meeting at the Mental Health Unit. The Patient Care Manager (P9) was not on the supervisory committee and was interviewed for the purpose of data collection and analysis. P9 acknowledged in her interview that psychiatrists have high workloads and massive patient waitlists perhaps contributing to their absence during IP meetings. Hence, it appeared to the PI during the IP meeting observations that the Patient Care Manager attempted to work around this conflict by sharing the leadership role with psychiatrists. Both Patient Care Manager and the Patient Care Specialist at the Mental Health Unit took accountability for discharge and led patient centric meetings by encouraging their team to provide input for patient status, length of stay, and communicate discharge plans if known. They led team meetings that were well organized in relaying information from the Emergency room to update the rest of their team. They also provided updates of new admissions and bed availability at other units in the hospital to facilitate discussions of patient movement at the Mental Health Unit. Overall, the shared leadership created a positive experience for those who attend IP meetings, which was also noted in the IP team meeting observations. P9 stressed the importance of "knowing the story of the patient" which often initiated solid conversations about patient treatment plans and possibility of discharge. Open communication was more evident during specific meetings run by the Patient Care Manager and the Patient Care Specialist, instead of the Psychiatrist, during which everyone on the team seemed more comfortable and more willing to share their insights and concerns of whether patients were responsive

to treatments and whether their family were involved and aware of the plan. These findings were consistent with studies that reported many professionals, including social workers, dieticians and physiotherapists find it more comfortable to speak with the registered nurses and that registered nurses were easier to reach than physicians (Day, McCarthy, & Coffey, 2009).

Likewise, the modified Collaborative Practice Assessment Test (CPAT) responses supported the role of psychiatrists as leaders in the delivery of patient care at the Mental Health Unit. The majority of professionals (six out of eleven) agreed the team leader, referring to the psychiatrist, is in touch with team members' perceptions and concerns. The Psychiatrist during the interview also acknowledged his role as a leader in making medical decisions such as prescription changes. The Psychiatrist's role as the ultimate decision maker was well understood by the rest of the IP team members, as both Social Workers interviewed and four Registered Nurses referred to the Psychiatrist as their team leader with authority to make the final decisions with patient care plans. The role of psychiatrists as leaders at the Mental Health Unit was clearly supported by patients during their interviews as well, in which they referred to Psychiatrists as "true professionals," "guides," and able to "better diagnose" their mental illness. Patients confirmed that psychiatrists, and in once instance the Social Worker, were responsible for communicating discharge plans to them. They also acknowledged Psychiatrists control their medication by asking how they felt and how the medication was affecting them. One patient stressed the importance of communicating with his psychiatrist by giving an example and stating that getting cared for by registered nurses alone will provide him with a "temporary solution" to his mental illness.

Patient involvement in IPC

5.2 Interprofessional Communication

Interprofessional communication is the NICF domain which describes how professionals of various disciplines communicate in a collaborative and responsive manner (CIHC, 2010). The various disciplines represented during IP team meetings at the Mental Health Unit included social workers, addiction counsellors as well as case managers. In each meeting, community partners shared feedback about their patient and family meetings, follow-up appointments scheduled, and referrals to outpatient programs. This feedback resembled a strong patient-focused approach to providing care at the Mental Health Unit. Six patients described Registered Nurses as helpful during their interviews and that there was good communication between Registered Nurses and Psychiatrists. IP team meetings were still focussed on addressing patient concerns, and this finding was similarly paralleled not only by patient interviews but also by the professionals' CPAT survey responses. Seven out of eleven professionals agreed that patient concerns were effectively addressed during IP meetings

However, there appeared to be a clash of perspectives between psychiatrists and registered nurses during patient discharge plan discussions. Similar responses the team "leadership" and "communication and community linkages" domains of the modified CPAT questionnaire were produced, such that five out of the eleven professionals surveyed disagreed communication strategies were effective when sharing patient treatment goals. Six professionals disagreed that the team had open and comfortable conversations during IP team meetings. Salhani and Coulter (2009) indicated this type of miscommunication can result from micro-political dynamics affecting how professionals

perceive their skills in communication, interpersonal and practical skills, and compare it to those of medical professionals. There was also one patient who expressed he was unhappy with his psychiatrist who did not seem too involved with his care plan. This finding was consistent with the breakdown in communication similarly experienced by professionals at times when the psychiatrists did not attend IP meetings. Hence, it seemed that frustrations built up when the psychiatrists were not present to communicate patient treatment plans and potential discharges, as stated repeatedly in the interviews with the Nurse Practitioner, Charge Nurse and two Social Workers. It was also apparent from the observations and interviews that these professionals were pressured by the conflicting needs of making beds available for newly admitted patients and the needs of existing patients not ready for discharge. This produced miscommunication and uncertainty, as professionals were not able to determine which patients were ready for discharge. These findings were consistent with results from other studies noting the lack of communication presents a barrier to the implementation of interprofessional collaborative practice (CIHC, 2010; D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005; Herbert, 2005; Pethybridge, 2004; Suter et al., 2009). Barker et al. (2005) also indicated barriers to interprofessional care include professional knowledge boundaries, professional culture differences, and a lack of knowledge about other professions' expertise, skills, training, and theory.

5.3 Interprofessional Conflict Resolution

Interprofessional conflict resolution is the domain of NICF describing how practitioners actively engage self and others, including the patient and his family, in dealing effectively with interprofessional conflict (CIHC, 2010).

5.3.1 Decision-making with a full IP team.

When it came to making decisions with the IP team, not all members on the team were involved and neither were the patients. Psychiatrists and Registered Nurses used patient care notes to share their updates, however both Social Workers expressed they were not included in the decision-making process. The Psychiatrist agreed it was difficult at times to include social workers with treatment plans and proceeded without their input, possibly due to factors such as the shortage in Social Workers, inadequate funding and/or issues of time management. Similar to other studies, the need to have a full and comprehensive interprofessional team attend IP meetings was highlighted in this study, such that physiotherapists, occupational therapists, social workers and registered nurses need to share their opinions in teams more effectively if they are to be competent and committed patient-centred practitioners (Atwal & Caldwell, 2005). A Social Worker said the IP meetings no longer include patients and a full IP team as very few psychiatrists were able to attend. The finding was again confirmed by the CPAT results from the coordination of care domain, in which only four professionals agreed patients are able to see multiple professionals in a single visit. A Registered Nurse expressed in distress that the team is unable to execute on patient treatment and discharge plans when psychiatrists are not present to provide their input. Another Social Worker recommended mandating

psychiatrists to attend those IP meetings would benefit by eliminating individual psychiatric ward meetings with patients.

Although psychiatrists were scheduled to attend psychiatric meetings with patients on a weekly basis, this was perceived as ineffective by members of the IP team as commented by the two Social Workers and Registered Nurse during their interviews. As supported by Jones and Plowman (2005), this could potentially eliminate psychiatrist individual meetings thus help psychiatrists save time, improve team communication and promote effective and efficient treatment/discharge planning. Jones & Plowman also suggested cases of criminal offenders suffering from mental illness are best discussed in a diverse interprofessional team with diverse understandings and explanations of harmful behaviour and the assessment of risk. Baker and Wellman (2005) similarly noted positive outcomes result when IP team members from various disciplines bring their experiences to the team by utilizing their knowledge of the community resources. Dealing effectively with the patient's problem can be achieved when professionals display the capacity to identify teamwork skills in the team and collaborate to allocate optimal resources **(**Drinka & Clark, 2000; Hornby & Atkins, 2000; Kvarnstrom, 2008). However, these optimistic views oversee tensions that can potentially arise from the differences in interpretive frameworks that professionals use for decision-making (Shaw et al., 2007). The study by Shaw et al. report that non-medical professionals feel that their capacity to negotiate new ways of working was limited by medical dominance. The impact of these professional power differentials on patients and the negotiation process however remain under-researched.

5.3.2 Shortage of social workers.

Kilfoil (2007) proposed challenges for treating patients with mental illness including insufficient resources, the lack of mental health facilities and programs as well as high workload between professionals. The shortage of social workers was another issue that was discussed during professional and patient interviews. One Social Worker stated she had to shorten her patient meetings to manage the high work load while addressing all patient needs. Patients found that frustrating and were "devastated" as the Social Worker described, when they were not able to receive more sessions as they expected from her. It was previously discussed in Section 2.1, that very little research on IPC reported on social workers and occupational therapists, so having included two social workers in the sample of this study adds to its uniqueness. Increasing diversity in the IP team by including Social Workers is essential when investigating the perceptions, facilitators and challenges encountered in the practice of IPC, as they also deliver services that impact patient outcomes (Watts et al., 2006). Many have expert knowledge about community resources, which are important to illness prevention, treatment and discharge proceeds of patients (Watts et al.). It was also apparent from the observations that community involvement was valued by the IP team at the Mental Health Unit such that a full group of community partners attended 94% of the meetings. It was also noted that community partners were engaged and patient centred driven as they often took initiative to follow-up and ensure patients were aware of their appointments and meetings with their families and healthcare professionals. This was further supported by the modified CPAT responses in which all of the professionals agreed their team has a process to optimize coordination of patient care with the community service agencies,

and eight out of eleven professionals agreed the team shares information about community resources. It was clear from the observations that the IP team valued their community partner input and integrated them with their patient programs. Again this finding was paralleled in the modified CPAT, with results showing nine professionals agreed the IP team established partnerships with community organizations to support better patient outcomes.

5.3.3 Discharge planning.

Discharge planning is a complex process requiring the collaboration of multiple healthcare professionals. The goal is to develop a plan for the patient prior to leaving the hospital and consequently improving patient outcomes and reducing costs (Shepperd, Parkes, McClaran, & Phillips, 2004). The push for discharge by the hospital produced a heightened sense of frustration with IP team members at the Mental Health Unit, as they modified discharge plans to make the discharge process more efficient and to improve patient outcomes. The Charge Nurse described discharge as chaotic when scheduled discharges suddenly change at the Unit. Some team members also complained in the interviews and from the observations that patient discharge plans were delayed due to the absence of psychiatrists who were primarily responsible for finalizing treatments and approve discharge of patients. The decision-making domain of the modified CPAT also confirmed everyone on the team agreed Psychiatrists made the final decision for patient care. In each of the meetings, the question of whether a patient was ready for discharge came up as a priority, and as professionals discussed length of stay and push for making beds available at the mental health unit for new admissions. A Registered Nurse further

confirmed discharge was not a patient goal but a hospital goal, and that all they did was talk primarily of discharge planning during these meetings. These findings are supported with previous research indicating delays in discharge have a significant impact on patient flow throughout the hospital and hospital admissions (Atwal & Caldwell, 2002). Thus healthcare professionals adhere to the hospital's organizational policies to contain costs and provide efficient service, and the implementation of mental health interventions becomes restricted by the hospital's budget (Campbell, Stowe & Ozanne, 2011). Some frustration was also experienced by some patients, for example the patient with Depression and Post-Traumatic Stress indicated his discharge plan was rescheduled without a set date. Patients are aware that the discharge process is collaboration between patients and their psychiatrists, as described by a Bipolar patient in his interview. Nevertheless, there were multiple incidents of patient readmissions and discharge plan delays as noted in the results Chapter Four. Hence, effective IPC approaches need to be adapted at the Mental Health Unit because effective IPC between team members facilitate better use of clinical resources, reduce healthcare costs as well as lower admission and readmission rates to critical wards (Dietrich et al., 2004; Interprofessional Care Strategic Implementation Committee (ICSIC) (2010); Reeves, Abramovich, Rice, & Goldman, 2007; Mitchell, Parker, & Giles, 2011; Tieman et al., 2006).

5.4 Patient-centered care

Patient-centered care is the domain in NICF which refers to how practitioners seek out and integrate the input and engagement of the patient their family and the community in designing and implementing care/services (CIHC, 2010). In the interviews

with patients and professionals in this study, participants were asked to share their experiences and expectations of patient-centered practice. Both groups were asked what patient-centered practice meant to them, and to provide examples of patient involvement in implementing care plans and services at the Mental Health Unit. The modified CPAT statements numbered 19 to 23 (Appendix D) were also used to determine the extent of patient involvement with the IP team and further confirmed themes surrounding patient-centered practice and identified in the interviews. First, educating patients of their mental illness symptoms and coping mechanisms and of the support available through community resources can motivate patients to change their behaviour, encourage engagement in treatments, and enhance transparency about their mental health issues. Second, providing a support structure for patients post-discharge and ongoing assessments are necessary to reduce the rate of readmissions back to the Unit. There was also mutual agreement among all study participants that involving patients and their families helps facilitate a smoother recovery for patients with mental illness.

5.4.1 Patient involvement and patient education.

Collaborative team leadership that involved patients and their families was not always evident at the Mental Health Unit when it came to formulating their care plan. Half of the patients interviewed said their families attended meetings with the Social Worker and Registered Nurses, and only two patients agreed they were actually included in setting their treatment plan with the IP team. Only those two patients that were involved said they felt supported by the registered nurses, and explained they were also able to get updates and discuss treatment plans. The remainder of the patients expressed

frustration with having delays or being unaware of discharge plans. Only five patients gave positive feedback about their experience of care in the clinic, and were satisfied with the goal setting and hope groups they attended. Hope groups at the Mental Health Unit is a type of therapy designed to help patients adjust to their mental illness, share their concerns, and find ways to manage their emotions. Previous research suggest that when group members share their experiences, this can help them become role models for one another, teaching each other coping strategies effective in managing the illness (Classen et al., 2001). One patient felt it was only beneficial to attend at times depending on who was running the group. The patient with post-traumatic stress disorder noted patients would be more willing to share their experiences in hope groups that were led by a Chaplain, who seemed more empathetic and comfortable to communicate with in comparison with having a group run by registered nurses or psychiatrists. P9 added her feedback about some negative patient experience from surveys completed at the Unit, in which she described during her interview that patients were often unhappy because they expected quick recovery with the help of a "magic pill". She added a point about their Mental Health Unit not being a hotel, similar to what the Charge Physician had previously mentioned in one of the IP meeting discussions. To her point, the patient diagnosed with a bipolar disorder answered she wished for medication that would work and help her live a normal life for a longer time span before she needed to come back for more treatment. Also, when patients were asked what their expectations of IPC during their interviews, patients suggested longer breaks, more food options and frequent garbage disposal in the lunch room.

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The responses from the patient interviews as discussed in Section 4.3.3 were also similar to responses noted in the contextual observations, in which psychiatrists were focused more on medication and procedural treatment plans, while registered nurses advocated strongly for community support needed by patients and their families. Also, the Social Worker stated in her interview that communication with patients was lacking and there was a need to educate patients about the community resources available to them. Similar to results obtained in other healthcare IP settings, it also appears that patients place professionals in a "negative and all powerful" category representing a reflection of the patients' feeling of powerlessness as they appear to be at the receiving end of multidisciplinary decisions (Barker & Walker, 2000; Happell, Manias, & Roper, 2004; Shaw, Heyman, Reynolds, Davies, & Godin, 2007). This is a strong indication that partnership between patients and professionals and ensuring patient involvement in treatment and discharge planning are essential to alleviate these patient's negative feelings. Observations of IP meetings suggested that there was a reduced focus on patient education of options of treatments and medication effects during IP team meetings. This was also confirmed during interviews with the professionals as one of the social workers stated patients were not familiar with the resources available and necessary to promote their recovery. Similar to other studies, the findings of this study support the need to educate patients and provide them with treatment and decision-support options to assist with their recovery (Howe, 2006). This is essential to motivate patients and ensure their engagement with interventions specific to their own personal situation, and when they better understand their diagnosis (HFO, 2010; Howe). One patient suffering from depression and anxiety and another with the bipolar disorder refused to attend therapy

sessions because they felt the groups were not useful. Three patients who suffered from depression stated in their interviews that there was a huge focus on medication, and another patient suffering from drug-induced psychosis said he needed to be more informed of how medications could help him cope with his illness as well as be informed of the possible side effects. Moreover, P9 said that often times, patients were not forthcoming about their addiction disorder or other mental health issues due to their fear of being ridiculed and stigmatized by society. Consequently this could make it difficult for registered nurses and psychiatrists to treat those patients and their recovery process could be slowed. Previous literature indicates that increased collaboration between practitioners and patients is correlated with positive outcomes of care such as increased motivation to change behaviour, enhanced acceptance of advice and improved self-management (Bissell, May, & Noyce, 2004; Canter, 2001; Howe). One patient suffering from depression stated she found group therapy sessions helpful in encouraging her to deal with her issues and work more closely with the IP team to recover. She said patients need to open up more and to allow professionals to collaborate with patients to help them understand how they feel and guide their recovery process. This was consistent with results from Campbell, Stowe and Ozanne (2011), which indicated that shared decision-making for a person with psychiatric disabilities has been identified as an implicit part of the recovery process.

5.4.2 Patient discharge and readmissions.

The delays in discharge resulted in increased length of stay for patients thereby creating another major conflict at the Mental Health Unit. Results in Chapter Four

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(Section 4.3.1.7) showed that patients were staying for thirteen, 44 and 51 days while waiting for treatment. The issue of lacking community housing resources also came about in one of the team meetings in which the Psychiatrist acknowledged patients could not extend their stay for the lack of housing reason. Having patients return to the clinic post discharge was an alarming concern raised by multiple professionals interviewed. One patient mentioned she needed to be more informed by the Registered Nurses and Social Workers about the community resources available to support her recovery after discharge. The Social Worker stated more than 50% of her patients at that time were returning patients within the last two months. This was suggestive of ineffective discharge processes in place, since successful discharges would result in no readmission back to the Unit and better equip the patient and their families for continuing care at home (Barrett, Curran, Glynn, & Godwin, 2007). Also, the Patient Care Manager proposed a reason for this high rate of return would be that patients were not accepting treatments and that they were unable to cope with their mental health issues. She also suggested a new post-discharge transition structure to support the recovery of patients with mental illness, as their average length of stay is twelve days when it takes a minimum of six to eight weeks alone for medication to be effective. A Registered Nurse said the needs of patients with mental illness are dynamic. Thus to help patients cope with changes to their mental health, ongoing assessments and a more holistic approach to care that is different from the medical approach is needed. The Nurse Practitioner also stressed the need to provide patients with medication support and group therapy sessions, as that could likely increase their cooperativeness with treatment and decrease the rate of re-admission. A patient with depression said in his interview that that a patient would not

reach a 100% recovery state unless they continue to collaborate with the health team after discharge. Cooperation and open communication between patients and the IP professionals are necessary since shared decision-making for a person with psychiatric disabilities has been identified as an implicit part of the recovery process (Campbell et al., 2011). These responses are directly correlated with the modified CPAT responses in which all professionals agreed patients meet face to face with team members caring for them, and seven professionals agreed patients were considered members of the IP team. Research supports a number of benefits to using IPC at healthcare settings, including enhanced patient self-care, better access to healthcare, shorter wait times, and improved patient outcomes (Barrett et al., 2007; ICSIC, 2010; Howe, 2006) as well as empowering patients when patients take an active role in their care (Curran, et al., 2007; ICSIC, 2010). Similar to those studies, all registered nurses agreed patients must be placed at the center of care which focusses on patient goals. The Nurse Manager explained that patients are involved from the time of admission when a plan of care is created. During IP meetings, there were discussions around patient responsiveness to treatment, transfers to outpatient facilities, and about visits by the patient families. Patient Care Manager encouraged open communication and discussions of patient scenarios during the IP meetings. IP team members appear to value the input of patients as partners. These findings are also true to previous research indicating that all healthcare professionals are trained to value patients, and are proud of their efforts to focus on the patient's best interests (Howe, 2006). All respondents' agreed that IP team members share healthcare relevant information with the patients, and ten agreed patients and their families were included in care planning. During the interviews, registered nurses and social workers mentioned it was important for

families to be involved with the process of care, since they can provide valuable feedback for how treatments can work with the patients living with mental illness. Registered nurses further added that having patients participate in the decision-making process helps these patients understand their own goals as they are experts of their care. Patients are seen as experts in their own lived experiences and are critical in shaping realistic plans of care (CIHC, 2010). Although professionals acknowledged the benefits to patient involvement in the IP team, the Charge Physician suggested there was a huge gap in actually including patients in the IP meetings, and that registered nurses should step in to represent patient views instead. Previous studies in primary care settings suggested active involvement by the patients in their recovery process showed significant improvements in clinical outcomes for people with depression (Campbell et al., 2011). Hence, it is important to involve patients in IP meetings and give them the opportunity to discuss their individual objectives. Previous studies also agreed that ensuring active involvement of patients with mental illness in their own treatment appeared to be a cornerstone of recovery **(**Davidson, 2005**;** Mead & Copeland, 2000; Noordsy et al., 2002) and improved clinical outcomes in primary care settings for people diagnosed with depression (Loh, Leonhart, Wills, Simon, & Harter, 2007).

5.4.3 Limitations to patient involvement.

Limitations to involving patients in IPC exist and depend on various cultural, interpersonal and intrapersonal factors (Howe, 2006). Interpersonal barriers to patient involvement are associated with effective communication with professionals, such listening carefully and having a clear, open and honest conversation (Levenson, 2002).

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Cultural factors refer to cultural differences in health disciplines and organizational structures in which professional hierarchies exist (Howe, 2006). For example, doctors accountable for high stakes outcomes may be culturally more averse to increased patient involvement and would need further education and encouragement to make this cultural change into a reality (Howe, 2006; Paice, 2006). The Psychiatrist said in his interview that patients have the right to participate in the process of care unless they were deemed medically incompetent. On the other hand, the Registered Nurse said that giving patients some control of their goals and validating their feelings would likely improve their willingness to collaborate with the IP team and acceptance of treatment plans.

Intrapersonal factors include psychological vulnerability due to their mental illness, acute pain or physical illness (Vincent & Coulter, 2002), and lack of knowledge (Chapple, Campbell, Rogers, & Roland, 2002). The lack of knowledge by patients was illustrated when a Registered Nurse commented some patients refused to get involved. When one patient suffering from Post-traumatic Stress Disorder was asked in his interview what his expectations were, he concluded that he was looking to receive medical stabilization and leave. Another patient with Depression said he expects Psychiatrists and Registered Nurses to communicate the treatment plan to him. This example shows that some patients fail to realize that mental illness requires ongoing psychological counselling besides medications, as well as developing a therapeutic relationship with the IP team and their families, and maintaining good and open communication. A patient diagnosed with a bipolar disorder explained in his interview it was difficult for him to focus and listen to multiple professionals during his team meeting as they all “spoke at once.” This finding confirmed that although involving families and

patients with care plans is important, there remain exceptions based on the diagnosis of the patient with mental illness. Li and Robertson (2011) stated emotional responses by patients are dependent on the clinical status and diagnoses. Additionally, Li and Robertson's study proposed other factors affecting conversational dynamics during interprofessional team meetings include room size, seating arrangements, and variations in preparing and presenting medical information. Due to the level of clinical interaction during their hospitalization, patients were most comfortable and wanted their psychiatrist and ward registered nurses present during these meetings (Li & Robertson, 2011). Although some studies may suggest including patients with a large IP team may provoke anxiety and distress, the study by Labib, Brownell, and Lawrence (2009) argued that the patient's opinion regarding the number of professionals attending their meeting was associated with their satisfaction about the meeting, and not the number of people present.

5.5 Team Functioning

Team functioning is the domain in NICF referring to how practitioners understand the principles of team dynamics and group processes to enable effective IP team collaboration. Previous literature explains that professionals find difficulties in sharing their knowledge when team members do not acknowledge, understand, nor respect each other's roles and knowledge contribution (Elwyn & Edwards 2009**;** Long, Kneafsey, & Ryan., 2003; Larkin & Callaghan, 2005). Moreover, team members can lose the holistic view on the patient's problem, lacking consensus and appear unable to present a united front to the patient (Kvarnstrom, 2008). Thus the team becomes unable to focus on the

collective performance and to deliver effective care and services to their patients (Kvarnstrom).

In the General Role Responsibilities domain of the modified CPAT, seven professionals agreed team members are able to negotiate their role in developing and implementing patient care plans. In the Mission, Meaningful Purpose and Goals Domain of the CPAT, six professionals agreed their patient care plans incorporated best practice guidelines from multiple professions. Also, eight professionals agreed their IP team members have a solid understanding of patient care plans, and seven agreed all team members were committed to collaborative practice. While both Nurse Practitioners disagreed, seven professionals agreed that there was a real desire to work collaboratively among the IP team. These findings were consistent with other studies which indicated their professionals agreed that IPC was occurring within their team (Pethybridge, 2004; Curran et al., 2007). From the General Relationships domain of the modified CPAT, nine professionals agreed team members respect each other's role and expertise within the IP team. The Charge Physician identified IPC as the collaboration between psychiatrists, registered nurses, social workers and community partners. Professionals indicated in their interviews the need to support each other as professionals and work towards a common patient goal. Similarly in patient interviews, patients identified IPC as team work that included psychiatrists, registered nurses and social workers. They also expressed this dynamic between healthcare and social care professionals was a way to provide patients with proper medication and care necessary to help them function in society. However, results in the CPAT showed that only two professionals agreed that patient concerns were being addressed effectively through IP team discussions, two disagreed, and the

remainder neither agreed nor disagreed with that statement. Moreover, seven professionals disagreed communication strategies were effective when sharing patient treatment goals. It was also evident from the patient interviews that patients were aware of the communication methods used by registered nurses and psychiatrists such as the patient care notes that documented their experiences and progress with treatments. One patient commented registered nurses and psychiatrists enjoy working in a comfortable and familiar environment where they support each other and find time to see their patients even after their shifts ended. These findings were consistent with previous studies indicating that healthcare professionals reported shared goals, common perceptions of a need for efficient IP interactions, explicit and complementary roles, and mutual respect for other professionals' expertise (Piquette, Reeves, & Leblanc, 2009).

5.6 Role Clarification

Role clarification is the domain in NICF which describes how practitioners understand their own role and the roles of those in other professions, and use this knowledge appropriately to establish and meet patient/client/ family and community goals (CIHC, 2010).

5.6.1 Understanding professional roles within the IP team.

From the interviews with professionals, it was apparent that team members acknowledged the critical role each of them played in providing accurate and effective treatments to patients with mental illness. The Charge Physician suggested Registered Nurses were representatives of IPC. Registered Nurses are the frontline workers and have

the most direct relationship with patients as they document their progress from the time of admission until discharge. Social Workers were recognized as transition managers who involve patients and their families in assessment plans and meetings thereafter to facilitate discharge. Registered Nurses also believed that Social Workers and community partners held the role of supporting with patient therapy groups and providing patients with community resources available to them. However, the Social Worker noted Psychiatrists held the ultimate power to finalize treatment plans and discharge patients, which was delayed when psychiatrists missed IP team meetings. The Nurse Manager explained this was due to their busy schedules and high workload; however psychiatrists still needed to provide their team with patient updates. This finding was consistent with the modified CPAT responses, in which one Nurse Practitioner and two Registered Nurses disagreed that physicians usually ask other team members for their opinions about patient care. These Registered Nurses results are similar to those obtained in other studies, in which they were reluctant to voice their opinions, rarely introduced new problems into the discussion, found it difficult to present relevant patient issues during team meetings, and answered questions as opposed to providing unsolicited information (Atwal & Caldwell, 2005; Manias & Street, 2001). Findings by Kvarnstrom (2008) similarly reported individual frustrations expressed by professionals in the IP team, which they related to weakening the team's ability to function and achieve results. It also suggested such feelings resulted when these team members perceive their team is not working in an ideal manner. They interestingly developed strategies such as engaging themselves in various forms of interprofessional learning and open group discussions in attempts to resolve these difficulties (Kvarnstrom).

5.6.2 Understanding the role of family physicians.

The IP team collectively agreed in their interviews, as documented in the Results Chapter (Section 4.3.2.6.2) that including more professionals, such as Psychologists, Occupational Therapists and Recreational Therapists, was needed to deliver more comprehensive and effective care plans specific to patient goals. Healthcare and social care professionals suggested Geriatricians and Occupational Therapists were needed for the elderly group of patients with mental illness in order to provide more accurate and effective treatments, a safer environment, and plans specific to their needs. They also brought up the issue of having Family Physicians create unnecessary referrals to Mental Health Units, and adding to hospital waitlists for mental health conditions that could be otherwise managed by their physicians. Unfortunately, limited resources in the community which creates a high workload for professionals, as well as the lack of facilities and programs for patients with mental illness represent challenges to treating them (Kilfoil, 2007; Mitchell & Giles, 2011). A systematic review of barriers to diagnosis of dementia in primary care identified family physicians are generally limited in early detection of dementia because of diagnostic uncertainty resulting from factors such as knowledge and experience gaps and pessimism about ineffectiveness of the treatment (Koch & Iliffe, 2010). The collaboration between qualified professionals is effective for specific patient populations including geriatric evaluation and management, congestive heart failure, and neonatal care and screening to improve the delivery of care to patients (Kilfoil, 2007). As previously stated in the Literature Review, Zwarenstein et al. (2005) further confirmed positive patient outcomes with such collaboration by proposing that measures of health status outcomes, disease incidence rates, mortality rates, readmission

rates, adherence rates, costs, and patient or family satisfaction, all strongly correlated to improved patient care and reduced costs. The study by Mitchell Parker, & Giles, (2011) investigating IP team effectiveness made several references to literature sources that indicated diverse teams are better able to make well-informed and comprehensive decisions, and develop more innovative solutions because they bring in different professional perspectives (Ancona & Caldwell, 1992; Bantel & Jackson, 1989; DeDreu & West, 2001).

5.7 Recommendations for the Mental Health Unit

5.7.1 Unified electronic notes for discharge planning.

From the perspective of the non-physician professionals such as registered nurses and social workers, psychiatrists need to attend IP meetings regularly to expedite the process of discharge and potentially decrease the length of stay at the Unit, thereby freeing beds for new patient admissions. As confirmed by existing literature on discharge planning, difficulties in implementing a patient discharge plan result from unplanned patient discharges and inadequate communication amongst team members (Watts, Pierson & Gardner, 2006). Therefore, this study recommends managing this issue of missing key members of the IP team by creating a unified electronic chart for each patient and including in it the most up to date patient information including discharge status (Miller, West, Brown, Sim, & Ganchoff, 2005). Making this chart accessible to IP team members directly involved with a patient's care allows access to information even when colleagues are absent during IP meetings, and hence facilitate a more efficient shared decision-making process.

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5.7.2 Communication tools for sharing patient and professional goals.

Communication is one of the primary domains of IPC, and strongly impacts all other competencies of the National Interprofessional Competency Framework (NICF) (CIHC, 2010). Hence, a breakdown in communication would make it difficult for the team to incorporate other competencies, for example collaborative team leadership, that are required to promote effective IPC in their healthcare setting and contribute to difficulties in implementing a discharge plan (CIHC, 2010; Watts, Pierson & Gardner, 2006). Hence, this study recommends that practitioners make an effort to recognize the diversity of other health and social care roles, competencies and responsibilities (CIHC, 2010). Effective communication can be achieved via eliminating professional boundaries and increasing sharing professional expertise with a common goal of providing patients with comprehensive healthcare plans in order to achieve optimal health outcomes (Mitchell, Parker, & Giles, 2011). An IP project team at the University Health Network (UHN) reported that professionals can establish better practices by developing evidence-based IPC interventions that are focussed on including the patient as an active member of the health team. Adapting such interventions requires improving current unit policies and procedures or establishing new ones, as well as dedicating time and space for IP team meetings (Poochikian-Sarkissian et al., 2008). Lahey and Currie (2005) further added that the lack of established structures and processes create barriers affecting interprofessional care. Hence, this study proposes that the Patient Care Manager, who already acts as a lead in IP meetings, creates a best practices policy or set of procedures for the IP team with structured examples and information to be shared about each patient in the patient care notes. This can be in the form of a unified checklist for caregivers having frequent

contact with the patient such as registered nurses and social workers. This checklist will be based on the patient wants and expectations at the Unit as stated in their interviews (see Chapter Four), and can include but is not limited to notes on: patient goals, patient cooperativeness and response to treatment, group therapy preferences by the patient, record of attendance to mandatory groups, length of stay and discharge plans set, as well as discussions with the patient with regards to utilizing community resources and other therapy options available to continue their recovery process post-discharge. It is expected that such method of communication can be effective in ensuring professionals have access to patient information and share their knowledge and expertise, and enable them to formulate treatment and discharge plans focussed on improving the patient-centered experience.

5.7.3 Patient involvement and patient education.

Patients may find themselves in a culture dominated by "discourse of treatment and care, control, and professional expertise" (Warne & Stark, 2004; Shaw et al., 2007). Therefore this study recommends including patients in care plans by acknowledging their feelings and by providing treatment options that can potentially reduce the power gap between patients and professionals and create a more positive experience for patients at collaborative mental health settings. This can promote patient-centered collaborative practice, in which patients are experts in their own lived experiences and their contributions are critical in shaping realistic plans of care (CIHC, 2010). The study suggests creating group therapy sessions with structured topics addressing mental health issues, symptoms and coping mechanisms and having a list available to encourage

patients to empower themselves by giving them the ability to choose to become involved in their care plans and facilitate a more successful recovery process. Providing patients with knowledge of medications and different coping mechanisms, understanding of their illness are essential to promoting a stronger sense of acceptance, enhancing patient transparency during their discussions with professionals, and improving their overall experience.

5.7.4 IP team diversity.

IP team diversity also facilitates the delivery of comprehensive care services to patients in their community (Kilfoil, 2007). Therefore, professionals of different backgrounds such as social workers, physiotherapists and occupational therapists can be included in the IP team at the Mental Health Unit to support therapy sessions and potentially provide a more comprehensive care plan to patients. This ultimately will support social workers and make them better able to manage their time and reduce their workload. Where human resources were limited, partnerships with local community resources are identified as an opportunity to fill staffing gaps associated with nursing and social work roles and improve the clinic's efficiency (Lee, Hillier & Weston, 2014).

5.7.5 Partnership with community members

The Charge Physician confirmed health and psychosocial professionals need to work together to follow-up with patients and engage community partners after discharge. He also suggested community and housing support are necessary to provide more comprehensive treatment plans for patients post-discharge. This recommendation is

supported by previous studies which proposed that professionals may achieve medical aims for the patient, however often ignore the patient's functional and social needs, and that all needs must be met to improve the patient-centered experience (Atwal & Caldwell, 2005). Also, studies reported the inability to establish and sustain comprehensive services to patients and allow informed patient choices achieves less than optimal patient health outcomes (O'Connor et al., 2011). Therefore this study also recommends considering sustainable sources of revenue and funding to support the delivery of comprehensive services involving patients as well a diverse selection of healthcare and social care professionals. Although financial resources are limited, alternate funding streams should be considered and pursued such as institutional funds, long term program grants, ongoing donor support and community fundraising events (Campbell et al., 2011). Also, appointing a committed community member as the designated lead for monitoring follow-up appointments, scheduling and running group therapy and recreational activities for patients, liaising with community services can alleviate some pressures from the social work shortage (Lee et al., 2014). The World Health Organization (WHO) (2011) recognizes IPC as a successful approach to strengthening the health workforce for future generations. A strong collaborative health workforce is recognized by many policy makers as an ideal approach to dealing with complex health issues. As previously mentioned in Chapter Two, psychologists are under-utilized despite the fact that 70% of consultations with family physicians involve psychological problems and concerns (Haverkamp, Robertson, Cairns, & Bedi, 2011). The Canadian Interprofessional Health Collaborative (CIHC), made up of Canadian health organizations, health educators, researchers, healthcare professionals, and students, developed the National

Interprofessional Competency Framework (NICF), with funding from Health Canada (CIHC, 2010). NICF is a Canada wide competency framework for IPC, which includes patient and community involvement as one of the six competencies designed to deliver effective interprofessional working relationships and optimal health outcomes (CIHC, 2010). As this is a policy direction supported by the government, this study suggests the continuum of services into the community with the reallocation of people resources as opposed to increased funding to support patients living with mental illness within interprofessional care settings. The question of whether there are sufficient resources in the community for patients with mental illness is an area that future research should investigate.

5.7.6 Patient decision-support aids.

Studies define clinical decision-support and decision aids as methods used to educate patients and encourage patient participation in decisions about their medical care (Campbell et al., 2011). Typically these methods provide information about treatment options, help patients clarify their preferences regarding the outcomes associated with each option, and support communication with their professionals (Elwyn & Edwards, 2009). Therefore, this study recommends providing patients at the Unit with decision support aids to support the decision-making process between patients and professionals (Deegan, Rapp, Holter, & Riefer, 2008). These aids may include peer support groups and workshops around medication uncertainty, and written and/or web-based materials and worksheets on coping mechanisms, symptoms and the uses and common side effects of psychiatric medications. This recommendation highlights another unique contribution of

this study, as there are very few data and limited guidance for decision support practices in the delivery of decision support to patients with mental illness (Campbell et al., 2011).

5.7.7 Workshops on best practices and collaborative teamwork.

Results of the study suggest patients refusing to engage in treatment plans appear to have also been aware of the breakdown in communication between IP team members at the Unit. Thus, effective team collaboration is needed to deliver more responsive and patient-focused services and promote these patients' engagement (Atwal & Caldwell, 2005). Existing literature reports that healthcare professionals must collaborate to ensure best practices for all patient needs (Quintero, 2004). IPC encourages cost-effective and improved patient care as it encourages innovation between professionals and empowers patients as active partners (Hyrkäs, Lehti, Paunonen-Ilmonen, 2001; Poochikian-Sarkissian, et al., 2008). Therefore, the study proposes that senior members of the team and/or leaders of the organization offer ongoing workshops sharing best practices and educational sessions on collaborative teamwork, in order to convey knowledge about interprofessional patient-centered practice (Poochikian-Sarkissian et al.). This creates a common vision motivating professionals to work together to improve patient care and consequently increase by-in from all team members including patients (Poochikian-Sarkissian, et al.).

5.7.8 Supporting the role of family physicians and psychologists.

Therefore it is recommended that Family Physicians receive interprofessional training regarding how to manage mild mental health conditions and become familiar

with community mental health services available to support their patients. The study by Barker et al. (2005) and Haverkamp et al. (2011) indicate there is a need to educate professionals about other interprofessional disciplines. Barriers to IPC include professional knowledge boundaries, professional culture differences, and a lack of knowledge about other professions' expertise, skills, training, and theory (Barker et al.). Moreover it was proposed by Haverkamp et al. that Family Physicians reported a lack of familiarity with the scope of practice and training of psychologists. Although 70% of patients seen by family physicians suffer from a psychological problem, psychologists still remain under-utilized in Canada (Haverkamp et al.). This correlated to the low participation rate by psychologists in the health sector. Hence, to overcome this challenge is to encourage psychologists to familiarize themselves with the operations of the healthcare sector through attending seminars and interprofessional networking events encompassing information about rules and power structures (Haverkamp et al.). Creating interprofessional educational seminars for healthcare students can also promote early learning experiences and help students establish effective and collaborative working relationships in the healthcare team especially as they enter the workforce (Ateah et al., 2010).

5.8 Strengths and Limitations

Strengths of this study include the high response rate of hospital inpatients. This improves the reliability of the study results because the PI was able to have in-depth interviews that were recorded and then transcribed for use as models of analysis. The one-on-one interviews were a strength of this design, such that intra-subject interaction is

eliminated and subjects' opinions are not swayed by other members at the clinic (Coolican, 2004). Also, inpatient interviews generated new findings about their role and perceptions of IPC at the Mental Health Unit. Investigating the role of patients with mental illness and evidence of their involvement in IP meetings is a novel concept that was not previously studied in Canadian mental health settings. Hence, this study analyzes in great depths the experience of inpatients, and draws parallels to those experiences and perceptions by professionals. It also compares the modified CPAT answers by the healthcare and social care professionals to those findings from the one-on-one interviews with the same group of professionals, hence adding to the validity of their responses. As previously mentioned in Section 3.8, methodological triangulation was used in this study to strengthen the quality of the research design, sustain credibility of findings and validate results using different data collection methods for obtaining observational, survey and interview data (Flick, 2007, chap.14; Shenton, 2014). The interference of a researcher's bias is inevitable in any questionnaire design; therefore, questions chosen for the CPAT and interviews targeted experiences and perceptions of the patients and providers as opposed to the preferences of the researcher. This is another method of triangulation which emphasizes confirmability and reduced investigator bias (Shenton).

Limitations to this study include the small sample size. Only the PI had access to questionnaire data and interview transcripts, and the Results did not identify any names in order to protect participant confidentiality. However, the small sample and setting of the Mental Health Unit may impose a residual risk of being identified by profession, for the group of professionals participating. Thus the study results for the professionals group

aggregated individual participants' responses as a tool to avoid inadvertent identification from the Mental Health Unit's small sample setting.

Since patients with mental illness can presumably be more emotionally vulnerable, participants may feel the urge to adopt responses that more likely represent the researcher's desired outcome highlighting the benefits of interprofessional practice. Limited information on the clinical status and diagnosis of patients was obtained. Working with various types of mental illnesses and existing comorbidities may have produced biased results since these patients do not share the same level of enthusiasm, educational backgrounds, and commitment to cooperating with the IP team. This could represent confounding factors affecting each patient's responses in their interview due to their mental illness (Carey, Lally, & Abba-Aji, 2014). Moreover, a need to provide a comparison of the voluntary and involuntary patient responses since admission status can significantly affect the patient's subjective experiences of interprofessional team meetings (Carey et al., 2014). There may also have been observer bias as the interviewer was also the author of this thesis.

CHAPTER 6

Conclusion

6.1 Uniqueness of Study

There is very little research on patient involvement with Interprofessional Collaboration (IPC) in the literature to date (Campbell et al., 2011). Thus, one of the unique elements of this study was that it examined from the patient perspective, the patients' role, lived experience, expectations and their perceptions of IPC. Unlike other studies, this research analyzed and compared responses from both patients with mental illness and their professionals under the guidelines of the National Interprofessional Competency Framework which was designed by the University Health Network to improve collaborative practice (CIHC, 2010).

Moreover, the uniqueness of this study was further highlighted as it included the contributions of social workers to IPC, whereas majority of studies that addressed the concept of interprofessional collaboration and interprofessional education focused on the communication between physicians and registered nurses only (Kilfoil, 2007).

There still remain limited data and guidance about how to implement interprofessional practice in the delivery of decision support to patients with mental illness (Campbell et al). Hence this study was believed to benefit current and future research in the field of IPC and mental health, as it offered findings and suggestions for empowering patients living with mental illness through the use of decision-support tools to promote patient-informed decision and patient-centered collaborative practice.

6.2 Summary of Recommendations

The collaboration between multiple professionals has been associated with positive outcomes such as reduced readmission rates, increased patient satisfaction, reduced costs and improved delivery of care to patients (HFO, 2010; Kilfoil, 2007; Zwarenstein et al., 2005). Since financial resources are limited, this study suggests revisiting the hospital's budget and alternate funding streams should be considered and pursued such as institutional funds, long term program grants, ongoing donor support and community fundraising events to support the inclusion of different professionals in the IP team (Campbell et al). Because the reallocation of resources is a direction strongly supported by policy-makers in the government, this study suggests using existing community partners and IP team professionals to run therapeutic groups for patients (Haverkamp, Robertson, Cairns, & Bedi, 2011; CIHC, 2014; WHO, 2011). Also, to reduce pressures created due to social worker shortages, a community member can be appointed as the designated lead for monitoring follow-up appointments, scheduling and running group therapy and recreational activities for patients, and act as a liaison with community services (Lee, Hillier, & Weston, 2014).

To improve interprofessional communication, this study recommends the hospital's Managers to develop policies and/or incentives encouraging the attendance of IP team members including psychiatrists. Lahey and Currie (2005) propose that establishing structures and procedures for the IP team can help eliminate barriers affecting interprofessional care. Thus, this study further suggests creating a unified electronic checklist of best practices and examples for what information must be included

in the Patient Care Notes. As mentioned previously in the Discussion Chapter, this chart may include and is not limited to issues identified in the findings such as patient goals, patient cooperativeness and response to treatment, group therapy preferences by the patient, record of attendance to mandatory groups, length of stay and discharge plans, as well as discussions with the patient with regards to utilizing community resources and other therapy options available to continue their recovery process post discharge. These Patient Care Notes should be made accessible to caregivers having direct contact with patients, as this can improve access to information by professionals absent from IP meetings (Miller, West, Brown, Sim, & Ganchoff, 2005). The study proposes to increase patient involvement by improving current Unit procedures and mandating the attendance of group therapy sessions in dedicated times and spaces, at the same time providing different choices from which patients are empowered to select (Poochikian-Sarkissian et al., 2008). Previous studies show that therapeutic groups allow patients to share their experiences and learn effective coping strategies from one another (Classen et al., 2001). Shared decision-making is a fundamental aspect of patient-centred care, and has been identified as an implicit part of patient recovery for patients living with mental illness (Campbell et al). Therefore, the study suggests developing written and/or web-based decision-support aids for the patients with mental illness to encourage their involvement and educate them about their mental illness, symptoms, medication use and effects, coping mechanisms, and treatment options.

Finally, Haverkamp et al. (2011) proposed that family physicians reported a lack of familiarity with the scope of practice and training of psychologists, and that 70% of the patients seen by family physicians suffer from a mental illness. Hence, the study

recommends educational workshops and continued training sessions addressing professional roles and benefits of IPC, as these can establish effective working relationships in the healthcare team and promote collaborative patient-centered practice as a practice orientation (Ateah et al., 2010; Campbell et al; HFO, 2010; Kilfoil, 2007; Margison, 2009).

6.3 Knowledge Translation

In context of working with the research partner at the Mental Health Unit and as a result of this study, the following recommendations have been successfully implemented. First, Registered Nurses from the Mental Health Unit are specifically assigned to look after patients admitted with mental illness as opposed to previously having Registered Nurses from the Emergency Department. This allows for more accurate assessments of the patient and focusses on setting patient goals upon their admission. Second, Child and Youth Advocacy Workers participate as members of the IP team to help understand the unique nature of the child or youth responses to traumatic events, and provide them with an encouraging therapeutic relationship. Third, to reduce patient waitlists for community housing, six crisis beds are being built to create convenience for patients and eliminate their need to relocate to other mental health facilities for housing accommodations purposes. Fourth, a number of group therapy choices including Pet Therapy and Arts and Crafts boxes have been incorporated into the Mental Health Unit program for inpatients to promote more comprehensive treatment plans. Fifth, a representative from the Addiction Counselling community partner conducts weekly visits to patients in the Unit to provide them with educational materials and the available community resources. In

summary, the relevance of this study and the knowledge gained have been embedded in the culture of research and successfully implemented at the Mental Health Unit to provide more patient-centered care.

6.4 Future Research

The purpose of this study was to investigate how patient involvement occurs with IP teams and the impact this dynamic has on the patient-centered experience. This study not only examined the patient's perceptions and expectations, but also drew parallels to the professionals' experiences while working collaboratively at the mental health setting.

6.4.1 Comparison of mental illness diagnoses.

Patients with different types of mental illness do not share the same level of competency, enthusiasm, educational backgrounds, commitment to cooperating with the IP team, and admission status (voluntary and involuntary), which are all factors affecting their responses in the study (Carey, Lally, & Abba-Aji, 2014). Hence, future research should provide a comparison of the patient responses and compare these factors to the patient's subjective experiences of interprofessional team meetings and degree of involvement (Carey et al). As psychiatric disabilities present challenges to patients in making decisions around medication use, and because these support tools are limited by financial constraints, the potential benefits from the decision support tools proposed in this study and their cost-effectiveness need further investigation (Deegan, 2008; Holmes-Rovner, Gruman,& Rovner, 2007; Loh, Leonhart, Wills, Simon, & Härter, 2007).

6.4.2 Availability of community resources.

Kilfoil (2007) also proposed challenges for treating patients with mental illness included insufficient resources and the lack of mental health facilities and programs. Future research can investigate the effect of community resource availability on the patient-centered experience, and the impact it has on the rate of readmissions at the hospital.

6.4.3 Impact of interprofessional power dynamics on patient involvement.

The study by Shaw et al. (2007) report non-medical professionals such as registered nurses and social workers feel that their capacity to negotiate new ways of working was limited by medical dominance. Tensions can also potentially arise from the differences in interpretive frameworks that professionals use for practice and decision-making processes (Shaw et al., 2007). The impact of these professional power differentials on patients and the negotiation process however remain little researched. Therefore, future research should examine the impact of these interpersonal barriers to patient involvement, on the effectiveness of communication with professionals such as listening carefully and having a clear, open and honest conversation (Levenson et al., 2002).

6.4.4 Validating research design.

Upon completion of this pilot, it is intended to reproduce this study with a larger sample size is necessary to increase validity. For example, a random sample selected from participants at different hospital facilities may improve the sample heterogeneity,

and consequently eliminate the threats posed by sample size and sample type on the external validity of the research design. Factorial analysis comparing the statement ratings of the CPAT could further add to the validity of the findings in quantitative values (Shaw, 2008).

6.5 Conclusion

This study explored approaches by which interprofessional practice can be used to support the delivery of patient-centered care in mental health settings. Daily meetings with an IP team took place to share information about patient admissions and discharge plans. Consistent with other studies suggesting registered nurses should be proactive leaders in discharge planning, it appeared that the Mental Health Unit Patient Care Specialist and Patient Care Manager alternately took the leadership role in facilitating team discussions (Macleod, 2006; Day et al., 2009). However, the study reported the absence of psychiatrists in IP meetings and shortage of social workers appear to have caused a breakdown in communication and created a sense of frustration for team members and patients**.**

Similar to previous studies, there was limited professional diversity in the IP team at the Mental Health Unit despite the need to provide patients with more comprehensive and patient-centered services (Salhani & Coulter, 2009; Kilfoil; Watts, Pierson & Gardner, 2006). Results of the interviews and survey also revealed findings similarly reported in other studies, which involved delays in discharge, increased length of stay, increased professional workload, and a breakdown in communication within the IP team as well as with patients (Ateah et al., 2011; Barker et al., 2005; CIHC, 2010; Coulter &

Salhani; Herbert, 2005; HFO, 2010; Kilfoil; D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu., 2005; Pethybridge, 2004; Suter et al., 2009). Some patients appeared to have negative and "powerless" experiences that are analogous to what was previously documented in literature (Barker &Walker, 2000; Happell et al., 2004; Shaw et al., 2007). Thus, shared decision-making is a fundamental aspect of patient-centered care, which must also include patients to empower them to continue taking accountability of their own health post discharge. This study's findings have been translated to new knowledge about the patient experience. As a result of this study, a few recommendations have been implemented at the Mental Health Unit to provide more effective patient-centered practice and address the challenges identified during the course of the study.

In conclusion, this research has identified gaps in the literature and created a guide to patient engagement with interprofessional teams to improve patient-centered practice in mental health settings. The contributions of a complete IP team, stronger focus on patient education, as well as the partnership with patients and community partners are required to improve the effectiveness and efficiency of mental healthcare.

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APPENDIX A

Literature Review Data Extraction Tool

Appendix A- Literature Review Data Extraction Tool

	Author, Year, Country	Sample Type	Design	Research Method	Principal Findings
1.	(Howe, 2006) Uk	purposive sampling	discussion article- Qualitative	Systematic review	- enhanced patient involvement shows greater patient satisfaction and the likelihood of positive organizational changes as a consequence of enhanced patient input -One of the greatest benefits of patient involvement is the potential to increase professionals' awareness that their actions have real consequences for individuals, which can moderate risk-taking behaviour -There is a link between increased collaboration between clinicians and patients and a number of positive outcomes of care – including increased motivation to change behaviour, enhanced adherence to advice, and improved self-management -SIGN the context of patient safety is one where relatively little work seems to have been done about the patient contribution. -Def of patient centred approach: literature does set out some specific

					findings on effective interpersonal behaviours which include willingness to help, mutual engagement and ‘‘safety netting’’, effective communication, and openness to giving and receiving feedback. Interestingly, these components strongly resemble those behaviours that are known to characterize a patient-centred approach. -Thus, best practice in interpersonal behaviours in the consultation may overlap to a great extent with those thatwill make a patient or their care giver feel included in the work and opportunities of a clinical team. The -there are significant factors that can reduce patient involvement applicable to both patients and staf: 1.intrapersonal factors; include psychological vulnerability (including mental illness), acute pain or physical illness, and the feelings of powerlessness or humiliation in those with chronic and acute illness, lack of knowledge, and because of professional domination. 2.Interpersonal factors include the important area of effective Communication and openness to giving and

					receiving feedback. 3.Professional defensiveness is a major cultural barrier to patient empowerment – professional resistance, emotional distancing, and negative attitudes can significantly reduce the effectiveness of patients' involvement. Doctors may be concerned that more proactive discussions of risks could have negative psychological impacts on patients, together with historical paternalism and hierarchy of medicine, means that doctors may be culturally averse to increased patient involvement, and thus may need additional encouragement and education to make patient engagement a reality. Patient limitations: patients with stable physical or mental health chronic conditions/settings are likely to have interest, capacity and expertise, whereas patients with new acute conditions or younger people might have interest and capacity but not yet have expertise to comment on behaviour of professionals, the (mal)functioning of equipment, or contest organizational procedures. Conversely, patients may have interest and expertise but have their capacity

					reduced; for example by impaired consciousness level or deteriorating -theme and next step: The literature for the effectiveness of interprofessional learning remains weak, and more work needs to be done on the extent to which patients want to be involved in their own care2 and the extent to which people are prepared to look at safety issues that may be anxiety provoking. When evaluating any interventions on interprofessional partnerships with patients, it is important to evaluate impacts on altered behaviours in real-life clinical settings, rather than on levels of perceived satisfaction or proxy indicators. -Further research is needed to explore the extent to which measures of effective teamwork correlate with patient involvement and positive safety measures.
2.	Poochikian-Sarkissian, S., Hunter, J., Tully, S., Lazar, N.M., Sabo, K. & Cursio, C. Canada, 2008	purposive sample included nine teams comprised of 75 health care professionals, representing a broad range of	Quantitative design to analyze survey results responses to the team focus group interview questions formed the qualitative	IPT developed an Interprofessional Practice Pulse Survey (Pulse Survey) and team focus	-resource tool kit was developed to facilitate teams in incorporating the interprofessional concept into practice. -developed an IPCP Framework to convey the various factors influencing the delivery of interprofessional care following the completion of the surveys and

		services, including primary and acute care. Team members included physicians, medical residents, nurse managers, clinical educators, advanced practice nurses, staff nurses, allied health members (physiotherapist, occupational therapist, social worker, dietician) and clerical personnel	aspect of the project. survey consisted of 16 questions related to team goals, collaborative practice, clarity of scope of practice, patient meetings, extent of shared responsibility, shared leadership, joint decision-making and inclusion of patient/family. A seven-point Likert scale was used ranging from "no extent" to "great extent" addressing team involvement.	group questions. Each team member from various departments within the selected organizations was asked to complete the survey questionnaire, followed by a focus group interview.	interviews, -facilitators to IPC include respect, good communication amongst professionals, and stability in team leadership. -barriers to successful IPC include time constraints, limited accessibility to patient information, lack of formal policies for implementing IPC, time for adaptation and hierarchical structures. -Developed a "novel" IPCP Framework: An extension of UHN's professional practice model UHN's PP model consists of different dimensions whose interrelationships reflect the organization's mission, vision and values (such as competence, compassion, leadership, patient family, collaboration) - Interprofessional Patient-Centred Practice Framework. Adapted from D'Amour and Oandasan (2004) -factors influence successful collaboration in healthcare teams including team interaction, clinical integration, knowledge transfer, and organizational factors. -The Framework includes the patient at the centre of the model and is the focus of the interprofessional team process.

					Organizational factors are included in the IPCP Framework as a supportive environment necessary to foster collaborative teams. The leadership within the organization must uphold a vision that values involvement of patients and their families, interdependence among team members and innovation. -pilot project concludes: interprofessional practice is an effective patient-centred approach. The inclusion of patients empowers them to become active partners in their healthcare. -study findings demonstrate that IP teams can clearly identify barriers and enablers to ip practice, however inclusion of patients as part of the team is an approach that is absent from their practice. - finding": Educational programs need to combine curricula as well as clinical practice to prepare tomorrow's practitioners for working together more effectively to improve patient care. Def: Knowledge transfer is the process whereby healthcare providers master new competencies (skills, knowledge,

					attitudes and behaviour) based on the merging of expertise and evidence-based research from different disciplines. E.g. of KT include education on collaborative practice, clinical best practice guidelines, change management skills.
3.	Shaw, 2008, Canada	Purposeful sampling is used to select participants, who include only English speaking adults, and received care from at least two health professionals at the FHC. The sample consists of seven patients, a family physician, a social worker, and a pharmacist.	Qualitative	observational analytic type of study, which fosters a qualitative methodology approach using direct observations, and semi-structured interviews. The study takes place at the Family Health Centre (FHC) of Toronto Western Hospital. The interviews are recorded	The author concisely describes the contribution this study makes towards the knowledge gap as there is limited research on patients' perspectives of interprofessional care. The article successfully identifies gaps within the context of Canadian primary care literature which seldom addresses patients' perspectives of interprofessional care. The author confirms the significance of the study such that patients' perspectives are essential to evaluating and improving healthcare (Shaw, 2008). The literature found on primary care mainly focuses on patient satisfaction as opposed to patient experiences; hence, patients' perspective is an area that needs further investigation. This study compares its outcomes with American and British reviews of the evidence on team based primary care. The latter is characterized by being more patient-sensitive,

				and then transcribed for use as models of analysis.	cost effective, and rewarding models for healthcare professionals. The literature search predominantly supports interprofessional collaboration as it is correlated with increased provider and patient satisfaction, increased access to care, and decreased hospitalization. Shaw (2008) also states some literature proposes that interdisciplinary care has no impact on patient experience and that some patients suffer confusion as a consequence. She clearly states the conflicting findings from several literature studies, and variable outcomes of patient satisfaction with primary care teams in terms of accessibility, consultation and the sense of being listened to. Results: propose the majority of patients are in favour of interdisciplinary care (Shaw, 2008). Patients appreciate the access to and perspectives offered by different interprofessional team members, and believe this can contribute to a well-rounded health service. One patient opposed the concept of open communication between professionals, such that he felt it breaches patient privacy. The patient rather preferred a distinct

					relationship with one professional (Shaw). Moreover, some participants who were classified as long term patients stated that they did not see any changes pre- and post- the adoption of the interprofessional model at FHC. Increased availability of services, continuity of care, and timely referrals were all significant advantages of implementing the interprofessional model as experienced by the majority of patients (Shaw, 2008). Although physicians play a more central role in the collaborative process, other team members are more involved with patients' appointments and share leadership responsibilities as well. While governmental policies, medical associations, and other professional associations in multiple countries adopt a patient-centered care approach, Shaw proposes significant study findings that suggest health professionals may resist patient-centered models due to their lack the understanding of how to put this philosophy into practice. This reasoning is convincing, and is supported in the literature Shaw uses in her paper to

					indicate the lack of patient integration in to the healthcare teams. Shaw further suggests this difference could also be attributed to gaps evident between theory and interprofessional practice. Shaw states that patients are beginning to become included in research; however, their full inclusion remains limited in areas of healthcare research, planning, delivery, and services. while the literature supports the theory of patients as full members of the interprofessional care team, patients are beginning to be included in research, their full inclusion in healthcare research, planning, delivery, and services is still limited. Fruitful areas of future research include comparisons of interprofessional versus routine care, investigation into why patients decline participation in interprofessional care, and cost analysis of interprofessional versus routine care. Exploration into how patients communicate their goals and the process of negotiating patient-professional common ground may further the

					goal of increasingly patient-centered practice and aid professionals in their quest to optimize health while respecting patient autonomy.
4.	Mann, K. V., Mcfetridge-Durdle, J., Martin-Misener, R., Clovis, J. Rowe,R., Beanland, H., & Sarria, M., 2009, Halifax	Purposive sampling Fourteen student teams, (total of 62 health professional students) each including one student from medicine, nursing, pharmacy, dentistry and dental hygiene, learned with, from and about each other while they were mentored in the collaborative care of patients transitioning from acute care to the community patients involved as	Students in their senior year were invited to participate by their respective faculties. Each team consisted of one student from each of dental hygiene, dentistry, nursing, medicine, and pharmacy. Clinical sites were asked to designate a member of their team to act as the integrative preceptor. Overall, 24 physicians, registered nurses and/or nurse practitioners from each clinical site served as integrative preceptors, acting as the supervising case manager	student intervention was offered twice, once in each of the first two project years. It consisted of several elements including an orientation workshop, ongoing educational sessions and an 8-week longitudinal clinical placement with an interprofessional student team -Students also	Developed experiential model of interprofessional education designed to extend classroom-based interprofessional education at Dalhousie to the clinical setting. ‘‘Seamless Care: An Interprofessional Education Model for Team Based Transition Care’’ was designed with the involvement of three health faculties (Medicine, Health Professions and Dentistry) for the purpose of preparing prelicensure health professional learners from dental hygiene, dentistry, medicine, nursing and pharmacy to become competent collaborative practitioners. Each of the patient groups who participated in the Seamless Care intervention had healthcare needs that required a team approach to their care and required active patient involvement for desired outcomes to be achieved. Through their assignment with these patients, learners were

		well; The criteria for patient participation were their willingness to participate in the intervention, which included a home visit from students, and ability to give consent. Included 18 patients- patients with diabetes, the frail elderly, palliative care recipients and patients with stroke. patients with gastrointestinal conditions; patients requiring physical rehabilitation; patients requiring nursing home care; patients with hypertensio	for the patient as well as the preceptor for the team's collaborative work. Twenty-nine university faculty members from within each discipline served as discipline preceptors, acting as a resource for students particularly for discipline-specific clinical or scope of practice questions. Both integrative and discipline preceptors participated along with students in the day-long orientation to Seamless Care, as well as interprofessional learning sessions noted above	participated, with their preceptors, in a variety of interprofessional modules delivered face-to-face, including topics such as interprofessional team learning, working with conflict, reflection as a learning tool, interprofessional communication, learning styles and reflection and reflective practice. Students reported spending 4 to 5 hours weekly participating in	actively involved in the framing of problems experienced by patients and in working with patients to develop and implement approaches to their solution. -goals for each team were to facilitate one patient's transition from acute care to home or nursing home care, and to develop skills in working with an interprofessional team in planning patient care. Students worked together with patients to address gap in the existing post-hospital discharge care. The patient intervention assisted vulnerable patients in the transition from acute care to the community by facilitating the patients' or families' central role in managing their illness.

		n; and patients with heart failure		this experience.	
5.	Reeves, S., Rice, K, Conn, L.G., Miller, K.L., Kenaszchuk, C, & Zwarenstein, M. , Canada 2009	Purposive sampling 47 participants representing various positions within nursing (floor nurse, nurse educator), medicine (resident, staff), administration (clerical assistant, clinical manager), and the various other professions (dietitian, physical therapist trainee).	ethnographic study	155 hours of observations and 47 Semi structured interviews were gathered with a range of health professionals from two general and internal medicine (GIM) settings in Canada. Data were thematically analyzed and triangulated.	-there is growing support for interprofessional collaboration in health and social care, both nationally and internationally. -When probed to reflect on their participation in interprofessional team meetings, nursing and other professional staff reported that they were anxious about engaging in dialogue which was medically oriented, despite the need to offer other, non-medical perspectives to the patient care -interactions between nursing and allied health staff during meetings were markedly different, as they tended to be characterized by more mutual exchange of information -interprofessional interactions between physicians and other health professionals within these GIM settings were terse in nature. -Interactions involving physicians and other health professionals were rare. When they did occur they were largely unidirectional – from physician to other professional asking for clinical information or requesting a patient carerelated task to be

					carried out. -argues that as medicine was the first healthcare occupation to engage in a closure project, it has claimed areas of high status knowledge and has the clinical influence to direct and shape most clinical interactions. As a result, while physicians' intraprofessional interactions and negotiations (with GIM colleagues who share their power base) were rich in nature and covered a range of formal and informal topics, they only engaged minimally with interprofessional dialogues. In contrast, interactions involving nurses, therapists and other professionals as well as intraprofessional exchanges were visibly different. These exchanges were richer and lengthier in nature and consisted of negotiations which related to both clinical as well as social content.
6.	Stacey, Legare, Pouliot, Kryworuchko, & Dunn, 2009, Canada	n/a	Qualitative-review/ theory analysis	Reviewed 54 publications for theory analysis of shared decision-	Most shared decision-making models were rated as logically adequate, but failed to encompass IPC and had limited descriptions of shared decision-making processes Findings highlight the

				making models and determine how they're relevant to IPC in clinical practice	need for a model that's more inclusive of an IP approach
7.	Lown et al. (2011) Canada	n/a	Qualitiative theory analysis	n/a	describe a model that can be used to design, implement, and evaluate continuing education curricula in interprofessional shared decision-making and decision support. IPC and shared decision-making are in need of improvement in clinical practice
8.	Politi et al. (2011), Camada	n/a	Qualitiativereview/theory analysis	n/a	providers need to communicate and maintain a shared sense of responsibility to their patient foundation for decision support for patients include: the ability to identify the decision dilemmas associated with patients' per- sonal, decisional, and clinical needs, patient-centered decision support and communication skills to support patient involve-ment, and the ability to work collaboratively and communicate with other members of the interprofessional specialty care team.
9.	Col, N., Bozzuto,	n/a	Qualitiativereview		Shared decision-making, with or without patient

	L., Kirkegaard, P., Koelewijn –Van Loon, M., Majeed, H., Jen Ng, C., & Pacheco-Huergo, V., Usa, 2011				decision aids, is essential to ensure high quality care for patients Suggest a series of teaching methods and propose preparation for concept of shared decision-making using five areas: : understanding the concept of SDM; acquiring relevant communication skills to facilitate SDM; understanding interprofessional sensitivities; understanding the roles of different professions within the relevant primary care group; and acquiring relevant skills to implement SDM.
10.	P Iquette, Scott Reeves, & Vicki R. Leblanc, 2009, Canada	Purposeful sampling was used to recruit our participants. healthcare professionals (nurses, staff physicians, and respiratory therapists)	Qualitiative	Semi structured interviews to get more answers (as opposed to focus group sessions).	During the pre-crisis period, healthcare professionals reported sharing a common goal: ‘‘jointly providing optimal care to each patient of the unit’’. To appropriately address patients’ acuity and complexity, intraprofessional and interprofessional collaborations were perceived as essential: -during crisis, A detailed understanding of the specific patient was no longer the focus of team members’ efforts. Rather, they worked towards taking the proper set of actions to resolve the crisis.
11.	Coleman,	Purposive	Qualitiative	Self	interprofessional

	M. T., Roberts, K., Wulff, D., Van Zyl, R., & Newton, K. (2008). Canada	sample of nurse practitioners, family medicine residents and social work students	longitudinal cohort study	assessments of team competence skills	ambulatory clinical training in primary care where learners work together providing care to patients can contribute to fostering both positive learner attitudes toward interprofessional work and development of team skills.
12.	Côté, G., Lauzon, C., & Kyd-Strickland, B. 2008, Canada	Purposive	Qualitiative	Historical environmental scan (historical over 10 yrs-reviewed 52 documents	there is active promotion and networking, concrete frameworks and funds but few published results regarding the efficacy of implementing IPC in healthcare organizations. As experience with the approach accumulates, evidence should grow.
13.	Schroder et al., 2011, Canada	Purposive	Mixed method-Qualitiative (questionnaire with open ended questions) and quantitative factor analysis	Interviews and questionnaire	Pilot testing of CPAT tool resulted in validating it as a reliable tool for measuring healthcare team members' perceptions of working collaboratively.
14.	Kvarnstrom, 2008, Sweden	Purposive 18 swedish health profesionals	Qualitiative	Semi structured interviews and survey following it.	Weak IP team functioning resulted from their perceptions of lacking organizational support, difficulty connecting, and from experiencing difficulties in using collaborative resources to arrive at a holistic view of the patient's problem.
15.	Campbell, Stowe& Ozanne, Usa, 2011 Outpatient	Purposive sample Purpose: to examine organizatio	Qualitative descriptive design	Conducted analysis of organizat	-Active involvement in one's own treatment appears to be a cornerstone of recovery for people with psychiatric

	Community Mental Health Clinic In Southwestern Us	nal factors that influences IP practice within a decision support environment focused on mental health issue		ional elements of the decision support centre that fosters IP practice and mental health patients support, through peer support groups and workshops, computer based decision aids, and worksheets on the use of psychiatric medication.	disabilities, and shown to improve clinical outcomes in primary care settings for people with depression . -Shared decision-making for a person with psychiatric disabilities has been identified as an implicit part of the recovery process. -initial and continued training is required for successful implementation of interprofessional decision support. Financial incentives such as paid time off for training and paying for accommodations and transportation will support professional training. Sign/essential to the question: -The shared decision-making process between a provider and patients with psychiatric disabilities, including the use of patient decision aids, has only begun to be researched and discussed in the mental health literature. -Coordinated and ongoing IP communication, continuing professional development, and decision support technologies are essential to support delivery of healthcare services in mental health practices. - Since there are many challenges for a person with psychiatric disabilities in making decisions around

					medication use, the potential benefits from interprofessional decision support programs for people with psychiatric disabilities need further research.
16.	Schmitt (2011) US	Purposive	Correspondence	n/a	Literature on physician-patient decision support, but lack in literature for the interprofessional support perspective
17.	Mitchell Parker & Giles, 2011, Australia	Purposive sample of 47 interprofessional teams in a tertiary referral hospital in New South Wales, Australia	-cross sectional quantitative design Dependent variables: professional diversity→ no. of professions in their team, independent variables: threat to professional identity, team openness	- Partial least squares (PLS) structural equation modelling (SEM) was used to analyse the data, as it is less vulnerable to measurement errors and effects of outliers, as well as can be used to analyze data from small samples ranging from 30 observations. It	-commitment and attraction to their team enhances members' ability to work together cooperatively. -professional identity plays a deleterious role by moderating an inverse relationship between diversity and effectiveness, suggests that professional dissent may increase the negative effects of diversity. (Results: 39% response rate: an inverse relation-ship between openness and identity threat, and a positive relationship between professional openness and team identity. Also diversity was positively associated with effectiveness at the low level of identity threat, and a high level of team identity) - management of interprofessional teams should incorporate interventions aimed at developing shared goals, shared vision and a sense of interdependence that

				has proven to provide more accurate correlation coefficients and significance levels. -Two different questionnaires were used to collect data, and measured responses using a 7-point Likert scale. - variables (professional diversity, team identity, threat to professional identity, interprofessional openness, and team effectiveness).	contributes to team attachment and identification. Essential to the question: to further research and develop the concept that interprofessional composition may not always be linked to improved performance -One of few studies to examine the impact of team identity and threat to professional identity in relation to diversity in profession and not demographics. How findings support thesis: The performance and compositions of a team depends on the team member's perceptions of social identity, e*g. strong sense of team identity-> improved performance, threat to professional identity is perceived→ stimulates hostility towards other professions and reduces team effectiveness.*
18.	Coulter &	Purposive	Data collected	Ethnogra	-reveals the complexity

	Salhani, 2009, Ca	sampling Data collected on one unit of a 368 bed urban psychiatric hospital in Canada The following unit professionals were interviewed: seven psychiatric nursing assistants, six psychiatric nurses, two psychiatrists, psychiatric residents, and social workers, and one medical resident, head nurse, psychologist, research coordinator, occupational therapist, physiotherapist, pharmacist, chaplain, and ward clerk. Associated	over a 12 month ethnographic study focused on understanding the actual relations among professionals in interprofessional healthcare work processes in institutional and community settings. The data gathering process for the part of the project presented here took place over a 6-month period in the mid-1990s.	phic methods included interviews, and intensive observations of an interprofessional psychiatric team in all aspects of its work, including interaction among team members, patients and family members, supervisors and administrators. -IP psychiatric team of 48 unit professionals were interviewed and recorded, while informal gatherings and discussions were	and robustness of micro-political dynamics (Reveals politics in IP context is an integral process in the formation of formal and informal alliances) in the constitution of professional and collaborative interprofessional work relations. - Imp to question b/c growing literature is found to offer strategies to accomplish IP team building, individual behavior changes, communications, but these often ignore the resultant constitution of competitive and political system of interprofessional teams. -The nurses employed dominance (power over) to achieve autonomy from psychiatry, resist the intrusion of other professions on their work content, develop and deliver desired work roles, exclude others from these desired roles, and expropriate the work of others (e.g. Formation of alliances and informal agreements between psychiatrists and non-medical professionals such as nurses created struggle around patients; treated as objects) -concepts of power, interests, struggle,

		disciplinary department heads, nursing supervisors, senior nursing and psychiatric administrators and hospital administrators were also interviewed in 45 min sessions		also documented. Data was transcribed and analyzed using ethnographic coding and data analysis strategies	alliances, and ideology can help us understand and explain dynamic interprofessional processes, professional strategies and tactics, and their consequences. Can a political a dilemma of governance in the health organizations contributes to the intensity of political struggles. -suggest that because of the reduction of organizational, administrative and clinical power of the medical profession by the actions of the state-sanctioned managerialism and other health professions, professionals will retreat to the safety of their own profession's interests rather than become magnanimous advocates for interprofessional collaboration. - further suggest that in the absence of an imminent reformation of the whole system of healthcare professions, there must be a formal political process to regulate and adjudicate professional and managerial interests and claims for organizational and work prerogatives and advantages as well as the complex ethical difficulties involved in interprofessional work.(Psychiatrists believed aetiology of mood disorders to be

					fundamentally biomedical, and perceived treatments other than pharmacological and biomedical therapies as unscientific. Nurses formed groups and performed various types of group and individual therapies, assuming they were within their nursing mandate.
19.	Kilfoil, 2007, Ca Halifax	Purposive	Mixed Quantitative Cross sectional; 12 HC professionals participated: guidance counsellor, a youth worker, three social workers, a police officer, a family physician, a community health nurse, a mental health counsellor, an occupational therapist, and two nurse practitioners. Participants consisted of professionals who were working in a rural Newfoundland community and who had	Mixed methodology was used for the research design and all professionals participated in face-to-face interviews	Professionals identified increased support, feeling valued and respected, and improved decision-making as benefits for them professionally. Participants saw teamwork as advantageous in treating mental health issues because it provided comprehensive care that assisted in keeping patients/clients in their home community. Drawbacks were that interprofessional collaboration can be time consuming and it is difficult to maintain patient/client confidentiality in a small community. Factors that helped enable interprofessional collaboration included familiarity and trust, physical proximity, being located in a rural community, and professionals' strong connections and commitment to the community

			completed the Rural Mental Health Interprofessional Training Program.		while challenges to treating mental health included a lack of facilities, programs, and human resources, as well as high workload among professionals. Their connection and commitment to the community seemed to strengthen collaborative practice, a finding that has not been discussed in the literature to date. there were no dedicated resources to coordinate mental health services, and most professionals had minimal training and experience in treating mental health.
20.	Margison, 2009, CA	Purposive	Case study design	Mixed methodology, Audio and video taped 2 workshops with 13 hc professionals and 1 patient, The recordings were transcribed and analyzed using the Roter Interaction Analysis	Although the team concept is not a new idea for health-care reform (e.g., World Health Organization, 1988), Herbert (2005) proclaimed that a change in practice amongst health-care professionals has not been successful in the past because there was no cultural change. for interprofessional practice to be a reality there must be a cultural shift away from health professionals being trained to practice in intraprofessional silos to the adoption of education and training programs that promote collaborative patient-

				System (RIAS), analyzed data with chi-square standardized residuals	centered practice as a practice orientation increasing the number of health-care professionals trained for patient-centered interprofessional team practice at both the entry and practice levels, and encouraging networking and sharing of best educational practices for collaborative patient-centered care (Herbert, 2005). An examination of the categories with variability indicated that the majority of the interactions were task-related and that the response patterns varied depending on whether the categories were grouped according to participant, workshop group, or profession.
21.	Atwal & Caldwell, 2005, Uk	Representative random sample	Bales' Interaction Process Analysis Tool was used	Direct Observational Study (14 team meetings)	- differences in way dif professions interact - inequality in participation - docs dominate mtgs - unequal participation within nurses - This will hinder patient care
22.	Haverkam, Robertson, Cairns, & Bedi, 2011, Canada	Review over last decade purposive	Review over the last decade	Interviewed 7 doctoral students of psychology and psychiatry	-professional identity is defined as a construct involving acquisition of discipline-specific knowledge, skills, attitudes, having pride in the profession, and the internalization of the values and philosophy of the discipline. It is not

					deliberately constructed, but is believed to be acquired through the process of professional socialization in graduate school. -Greater participation by psychologists in the healthcare sector has been recognized over the past decade based on increased awareness that psychological wellbeing is important to overall health. The report stated 70% of consultations with family physicians involve psychological problems and concerns. Unfortunately, psychologists are under-utilized in the health sector, and there remains insufficient funding for psychological services. Also, most mental health services are delivered in the private sector and available to few Canadians. 2-Greater participation in health sector has also been faced with as several authors reported physicians and psychologists have limited knowledge of the culture and content of each other's work. Psychologists need to familiarize themselves more with the operations of the healthcare sector, including rules and power structures. Family physicians reported a lack of familiarity with the

					scope of practice and training of psychologists, and how that training differed from those non-regulated professionals. -Recommendations made included advocating for accurate representation of counselling psychology credentials in the workplace and educating other health providers on the training and identity of their profession.
23.	Barker, Bosco & Oandasan, Canada, 2005	Snowball sampling technique. Initially surveyed informants from various professions across federal, provincial and territorial governments, healthcare and educational sectors in Canada. In the survey, respondents were asked to name others whom they believed should be included in the scan because of	Grounded theory analysis to identify factors associated with IPE and IPC practice initiatives.	Web based survey to identify key informants, and then conducted semi-structured telephone interviews with the key informants. Interviews were transcribed by a contracted administrative assistant and analyzed using	The medical profession posed challenges in terms of cultural beliefs about collaborative practice and interprofessional practice, as they were more resistant to reaching out to and joining with other professional groups. -Champions are defined as individuals who had major roles in being communicators and convincers in disseminating information about IPC and IPE initiatives. They are needed to ‘‘stimulate change, interest and commitment across a variety of stakeholders’’. -professional “turfs” are important to consider and so the difficulties of changing entrenched professional beliefs and cultural prescriptions of how to educate health professionals act as a barrier to the success of IPC/E initiatives.

		their expertise and/or experience.		grounded theory analysis techniques and NVivo was used to support data analysis.	
24.	Ateah, Snow, Wener, Macdonald, Mege, Davis, Fricke, Ludwig, & Anderson, 2010, Canada	Purposive 51 Pre-licensure students from health professions at the university of Manitoba	Focussed group sessions in classrooms and collaborative practice settings. To determine health perspectives of other professions, students filled out a Student Stereotypes Rating Questionnaire (SSRQ) which consists of a five point Likert-type scale ranging from 1 (very low) to 5 (very high). Each group rated health professionals on nine characteristics: academic ability, interpersonal skills,	Quantitative a modified experimental pre-test, post-test design	Ateah et al. (2010) stated profession specific stereotypes exist ever since students complete their professional programs and begin careers with certain perceptions or understandings of other professions that may or may not be accurate. These perceptions remain as unchallenged ideas because the students do not have opportunities for direct interactions with students from other professions. - Learning together in an interprofessional environment can make important contributions to the perceptions of health professions. Such early learning experiences can help students establish effective and collaborative working relationships in the healthcare team. Following participation in interprofessional education, students in this study rated all participating healthcare professionals higher than

			professional competence, leadership, practical skills, independence, confidence, decision-making, and being a teamplayer.		they were rated prior to the interprofessional educational experience.
25.	Cihc,2010, Canada	Representative random sample	Grounded theory Design	Method-working group of CIHC volunteers provided oversight and advice on the development of the Canadian Interprofessional Competency Framework. An external group was contracted to review and summarize the peer reviewed and grey literature as well as	Effective IPC is dependent on six competency domains, as outlined by the National Interprofessional Competency Framework:: 1) interprofessional communication 2) patient/client/family /community-centred care, which promotes sharing information with patients (or family and community) in a way that is understandable, encourages discussion, and enhances participation in decision-making. In patient/client centred collaborative practice, patients/clients are seen as experts in their own lived experiences and are critical in shaping realistic plans of care. 3) Role clarification is one domain in which practitioners should be able to describe their own roles and that of others, while also recognizing the diversity of other health and social care roles, competencies, and responsibilities.

				selected competency frameworks.	4) team functioning 5) collaborative leadership 6) interprofessional conflict resolution
26.	Health Force Ontario, 2010	Purposive	Qualitative descriptive design	visits to colleges and universities to explore the perceived benefits of IPE and ways to improve its implementation in the education sector Following the scoping reviews, site visits were undertaken at representative colleges and universities in Ontario so that Working Group members could learn	-Implementing IPC, and establishing a firm base for IPE requires the commitment of a range of stakeholders, including regulatory bodies, healthcare professional organizations, academic institutions, hospitals, insurers, community and support agencies, organized labour, researchers, patient/consumer groups, government, crown agencies, healthcare professionals, educators, administrators, patients, and families. -Committee developed four key recommendations and identified associated activities. These provide an effective framework for implementing interprofessional care: • Building the foundation: creating a firm foundation upon which key interprofessional care activities can be implemented and sustained. • Sharing the responsibility: sharing the responsibility for ensuring that interprofessional care strategies are effectively implemented among interested parties. • Implementing systemic

				firsthand about the perceived benefits of IPE and suggest ways to improve its implementation. Interviewees expanded from the institutions' deans and program leaders to include the faculty, staff, and students involved with interprofessional education in various capacities. Project information and interview questions were sent ahead of the visit	enablers: providing systems, processes, and tools that will allow interprofessional care to be taught, practised, and organized in a systemic way. • Leading sustainable change: leading sustainable cultural change that recognizes the collaborative nature of IPC and embraces it at all levels of the healthcare and educational systems. --IPC benefits-service improvements to patient care delivery (see Figure 2), including: • increased access to healthcare • improved outcomes for people with chronic diseases • less tension and conflict among caregivers • better use of clinical resources • easier recruitment of caregivers • lower rates of staff turnover IPC not only benefits the patients, but professionals share the burden, reducing stress, burnout, and increasing job satisfaction. Found there's a commitment to IPE across Ontario that can be sustained through sharing the knowledge of IPE with schools and organizations concerned with health

				to key site contacts. Telephone conferencing was used for some participants. Face to face interviews with 9 colleges and 12 universities	sciences education. Developed Integrated Interprofessional Education Model, a new framework serving as a guide for teaching and assessing interprofessional competencies.
27.	Who, 2011	Representative random	Total of 184 countries in the WHO regions: Africa, America, Western Pacific, Eastern Mediterranean, Europe, South East Asia	A survey was sent to all Member States and Associate Territories. Data were obtained from 184 of 193 Member states, covering 95% of WHO Member States and 98% of the world's population.	Some countries unable to provide data for some indicators (eg. Unable to provide budget for mental healthcare since integrated with hc) Outpatient facility, policy, and primary care facilities vary between countries (70% SEA countries reported having a mental health policy but only 32% of the population is covered) More mental health policies present in Europe and South East Asia and Eastern Mediterranean

				Atlas online question naire (Word version available upon request	
28.	Watts, Pierson & Gardner, 2006, Ireland	Representai ve random	218 Victorian critical care nurses	quantitati ve descripti ve design Survey	Workload issues, unplanned discharges & inadequate communication contribute to difficulties in implementing a discharge plan
29.	Curran, Sharpe, & Foristall, 2007, Canada	Representai ve random	Medicine, Pharmacy, Nursing, and Social Work programs Faculty Members at Memorial University, Newfoundland Ontario	Survey	- Faculty attitudes are believed to be a barrier to successful implementation of interprofessional education (IPE) initiatives within academic health sciences settings -Medical faculty members had low mean scores compared to nursing faculty on attitudes towards IPE - Neither age nor years of experience as health educators affected their attitudes towards IP teamwork, - Female faculty and faculty who had prior experience in IPE had higher mean scores.
30.	Thomas, 2008, US	Representai ve random	39,017 medical, surgical, and cardiology inpatients who received care on general, intermediate, and intensive care units.	Quantitat ive comparat ive Case Studies	- defined role functions, collaboration and communication expectations, and defined documentation expectations positively influenced levels of care

			Used inferential statistics for analysis of data		

APPENDIX B

Contextual observations Notes

Day 1

Meeting is led by the Nurse Manager, the physician is present as well as a group of nurses.

Discussion of patient status, medically cleared to go, bed situation and potential discharges discussed. A Nurse asks the physician: "What happens to them after the patient leaves? Transfer to psychiatrists?", Physician answers: "Yes, he'll transfer."

Another patient has no place to go, put him on ALC (alternate level of care). It's day 15, it's too long the Nurse says it's a housing issue.

My impression is that there is a huge issue in the communication during meetings based on the professionals' perspectives of what's good for the patient. Differing perspectives perhaps clash of cultures and core values, the perception of wellbeing of patients from a physician, versus social worker versus administrator at the unit.

"There's a lack of resources, this is huge, and the lack of options for families and couples. There's a social pressure to discharge versus complete with well- being piece, versus Nurses that describe themselves as advocates for patient", the Nurse Manager says to me.

I see Nurses advocate for care while physicians mostly focussed on medication and not necessarily aware of the patient's full story and the family, what does the patient want. This wasn't mentioned at all during the meeting. After the meeting, discussion continued between nurses and social workers about why the doctor wants to keep a patient they believe can be discharged. I see the issue and focus of my project is not discharge but admission of patients and the inpatient experience."

Day 2

Meeting with nurses, no physician. Charge Nurse, Nurse Manager, Pinewood addiction counselor and community support workers present. IPC meeting was led by Nurse Manager. Talks about inpatient transfers to outpatient facilities and process. Patient is responding to ECT treatment, Manager seems to really know the patient and open communication observed between Nurse Manager leading the IPC meeting with nurses. Nurse Manager asks "Does anyone know the story of this patient?.. Talks of the patient and involving his mother were mentioned. A patient's discharge is for mid-week, and patient was described as being receptive to treatment and family is cooperating and

understanding. Another patient is waiting for Ontario Shores (outpatient treatment facility) and does not want to go home so she doesn't lose her bed.

Another patient is waiting for test results, patient is psychosomatic when it comes to meds. Can she go home and wait for Ontario Shores? A nurse answers: No because she'll lose her bed. Nurse in Charge is determined to talk to patient and say: You have to consider alternate accommodations when this isn't working out for you.

A third patient doesn't want to go home, patient is on a group home wait list, schizophrenic. So needs to be connected to ACT team and fully supported by community.

Nurse Manager asks: Is there any progress with patient n? Nurse says no way she'll be accepted into a nursing home, so we'll see what is in the best interest for her since with her condition she cannot meet a lot of criteria unfortunately.

Nurse Manager: we have several patients in EMERG, he will require a bed so we need some movement. Nurse Manager from 8:10 meeting communicates with Nurse Manager leading IPC meeting.

Day 3

IPC meeting has a Durham Mental Health Counselor, 2 CMHA Case Managers, 2 Social workers, CCAC coordinator, Nurses and 2 Patient Care/Nurse Managers.

Meeting is led by nurses mostly today, and community partners. No physicians involved.

Meetings were more efficient today, much more patient focussed, and individuals were volunteering to look after patient/update patient with information and talk to the patient. initiative driven, and patient centered meeting clearly displayed by saying "I will check with patient x to see if they're aware of meeting with Dr. and their appointment follow-ups scheduled"

Also, environment of meeting was more relaxed and everyone got a chance to contribute, not intimidated since physician is absent (my thought right now?) and more open communication during the meeting. This is different from day 1 when nurses and social worker still communicated concerns between each other and felt disagreement with resolution of some patient cases.

Day 4

Discussion of patient, rehab will not take him so what are the next steps, Nurse Manager asks. Choice to make as an adult, the doctor said that to the patient previous day. CCAC have already been connected with him before he was last discharged. He was offered choices, before he was discharged, so we just need an EOD to get services in place. The Nurse said we told the patient we cannot get you to a nursing home, it's not an option.

My thoughts: Again there was no physician present in meeting. One is on vacation, and there's only one doctor assigned so whoever takes care/fills in is the "on-call doctor". During IPC meetings, on call doctor is upstairs working on discharges while the rest of the team attended meeting. It seems that doctors in general do not believe in attending meetings is a necessity or priority, and the team of nurses and social workers and community members affiliated are the ones who take the lead, and are accountable for discussing patients' situations and follow-up with patients mentioned in the meeting that Doctor so or so had the conversation with patient x. or talked to mother of patient y, but the next steps are often determined by the IPC team who are more involved with patients' recovery process, the inpatient experience shaped through them. I recall the social worker was offering an 82 year old female patient the Bible and making her happy. And another from previous day's observation volunteered to talk to the patient and offer them options as to where they want to go after discharge and treatments available.

There's pressure to discharge which is often mentioned in meeting and talk of number of beds available and length of stay. I recall a Nurse Navigator who walked into the meeting asking who the doctor in charge is. Frustration comes from stigma perhaps on Mental Health staff as the Nurse Manager and other Nurses feel during the manager's bed meetings that take place prior to the IPC meetings. Other units they feel are given more priority perhaps, to treat their patients, not sure so I need to investigate maybe through my interviews what the perception of mental health patients is. Some more thoughts: having to get to know your patient at the unit, is the patient discharge affected by diagnosis, are patients being discharged because of their behaviours, what are the reasons, what if it's because patients have gone beyond the norm of length of stay, would discharge planning be affected?

Day 5

Discussion between the Nurse Manager and myself about reasons for discharge. Discharging patients sometimes after they're met the 5-12 length of stay maximum and have to leave, if it's because patients are causing too much trouble or demanding and team don't want to handle those patients, i.e. Reasons for discharge and whether it's for the benefit of the patient really.

The Nurse Manager begins meeting. Reads through the list of patients, status of discharge, are they ready to go, need to speak to the doctor to confirm.

Patient x is having an ECT so will be discharged in 2 weeks, and St. Mike's will arrange surgery after ECT is done. Then we need to know the next steps, make sure we have a CCAC referral in, the Nurse Manager says.

CMHA representative states he met with another patient. Nurse Manager says patient is supposed to be discharged Saturday, today is Monday, this didn't happen so we need to speak to the Doctor about that, we just don't know but we need to make sure patient is ok.

Another patient came in last night, never heard back from Ontario Shores because the Shores are waiting for MRI results.

Another patient, the doctor wants to make ALC, he's pushing for it, the Nurse Manager says. But he's not ALC, he's still active treatment. But he won't participate in psychiatric assessment and Ontario Shores won't take him without assessments. This patient is blind, hugely decompensated (behavioural problems and yells at the Nurses all the time). Another Nurse Manager says, we should do our due diligence and get the referral going, worst thing that will happen is if they say no, if no then we can get back to boarding step and see what options are there.

Thoughts: During the meeting, patients receiving ECT treatments are quickly looked at, ok we can't do anything about the discharge yet. Going fast though it and not really discussing the next steps or how discharge will be. Question now is if the treatments patients receive hinder the discharge planning of patients…

Day 6

Patient is doing ok with the patch it's fantastic. Patient x's mom passed way so we're going to have to look at re-integrating her back. We need to move people around so we can have room for 2 people we're admitting a male and female, the Nurse Manager says. We need to get the script from Doctor to move things.

Nurse Manager asks, how is patient doing, is she supposed to be discharged today? Nurse answers, I don't really know what the plan is, I'm just reading on it because he's only in the 5th day. Another Nurse says I met with the patient yesterday and she may be interested in our Drug Program. Nurse Manager, Excellent. The doctor has his meeting today, so hopefully the patient will be presented at the doctor's meeting. The Nurse Manager communicated the two patients being admitted into clinic and the doctor said will do well just on the floor here. 2 females and both are on form 1 and are short stay and not PICU. So that's why we can do some moving. Don't know if they're more suitable for RASU and there're 2 patients that seem to be doing well and want to be discharged.

My thoughts: communicating information from the ER meeting gives everyone a chance to know what's happening with the patients and what to expect to receive with admittance. For my thesis I'm hoping to talk about the next steps and how I can make this process more effective for meetings and IPC meetings and how they can be more patient focussed.

Day 7

The Nurse Manager again is leading the meeting. Social Worker, 4 Nurses only, no DHM/CMHA/Pinewood partners, 6th nurse came after 10 minutes. Charge Nurse is absent, also a team leader who does assignments of beds and coordinate floor in conjunction with Nurse Managers at the Unit. Key players from community agencies are not present, affects discharge process.

Patient x has been here 10 days, and we need to find out from Doctor when she can be discharged. Too bad we don't have a team leader here to tell us about the discharge plan.

Patient y has been accepted to Ontario Shores, and just waiting to go.

Patient z, we don't know if she's going to get discharged today.

Patient m, don't know either, we need to follow-up with doctor, she's getting second and actually 3rd diagnosis.

Patient n, mom keeps calling, she also needs a lot of help, this should be counted s "double" because the patient and mom both need help.

We'll let Doctor know not to let everyone out on Friday (ie. Discharge is what they meant).

Patient o, has been here for 13 days and will go by end of this week.

Patient l, 13 days and supposed to have gone yesterday. I'll speak to the doctor today and see what we're supposed to do.

Doctor's meeting with the patient tomorrow, so I guess he will give him discharge afterwards..

Social Worker: I met with him today and his family, and educated them about depression. He's pretty much hooked up and ready to go.

Talks about another patient, outburst and delusion medication, but nothing is working, the patient says "leave me alone", and we consulted two doctors about it already.

My thoughts for the day: giving the patients too much power can sometimes increase length of stay I'm thinking. It's still the same hospital and if need to move patients according to need of treatment, why let patients get to decide and say no?

Day 8

Patient involvement in IPC

Much larger presence of staff, about 10 people, nurses, Nurse Managers and Social Worker. A Nurse says "Pinewood is not here today, so we have to follow-up". Doctor came in the middle of meeting and spoke to the board with patient names and los status, he said "I'll talk to this patient and please schedule a meeting with me, and other patient on Monday 8:30am". Doctor seemed knowledgeable and aware of patient situations, also cooperative. It's my first time seeing him today but he seems like a good team player as he asked the Nurse Manager about the list of patients

Nurse Manager asks Nurses and Social worker: "Do you have any more information about patient z? Do we need to put in a social work referral?"

Patient z lives in Windsor, supposed to be discharged tomorrow and don't have a reasons why not discharged today. So we'll talk to doctor and see what the situation is.

Day 9

Meeting includes Charge Nurse, Nurse Manager, Social Worker, and Case Manager.

Nurse Manager asks, patient x has a son, who's watching the son, has the son been in at all to visit her? Have you had any contact with him?

Nurse answers I think they need a lot of support in the community.

Nurse Manager says: ok we'll have to talk to Doctor if we can send her to a home and continue medication there because she doesn't really need to be here.

With patient z, everything is ready and the doctor wrote discharge on Friday so she'll be discharged today.

Patient m, case worker had seen him a few times and Ontario Shores declined but he's still here. Nurse asks if could move patient to rapid assessment unit (RASU).

Nurse Manager asks what's good for the patient because the patient likes routines and may get upset if moves too much, so it's not a good idea to move them to RASU.

Case worker says "there're supports in the community, would you be willing to try that, but the patient says no and threatened to kill himself or someone else."

Nurse Manager says "So we have to speak to the doctor and make a decision, and tell the Doctor what exactly this patient said."

Patient n, he knows he needs to be discharged and is good to go!

Thoughts for the day: at today's meeting, the patient has been mentioned a few times as well as their family involvement. How the patient reacts to their movements in the unit to create capacity was also taken into consideration. No physician was present at the

meeting, it's very frustrating that we don't have their input when discussion of patients take place, so options A, B, C, D but when and what can't be determined, stuck! A lot of times, nurses can proceed with discharge but doctor likes to see the patient again before they leave, the Nurse Manager explained to me earlier. Nurse Manager said "so this slows process down. This is a very physician driven process when Nurse Managers are the ones accountable for discharge numbers and charges. Nurses are hesitant to make decisions for discharge even when an order was completed with forms signed."

Day 10

No social worker, no physician present. Nurse Manager is leading meeting again, there're nurses and a CMHA rep.

Nurse Manager: Did we check if patient x had interest with the CMHA program? The CMHA rep answers she hasn't had a chance yet.

Nurse Manager says we can move patient y to RASU. Patient M is starting ECT, and don't know if the CTO coordinator was here, patient fits criteria but is uncertain now. So gave her my information and told her let me know if you'd like the service.

Nurse Manager: Patient z is extremely abusive, get in touch with OGB. For patient m we need to follow-up with doctor because I need to know how his meeting went.

My thoughts: there's a lot of pressure today to try and get people out and a lot of pressure to move people to RASU. No social worker present, 3 of one doctor's patients need to go, with a plan in place but it's frustrating because no orders are written to discharge and no response from the doctor. Nurse Manager is stressed, says: "we have 3 PICU admits downstairs and we have 10 in RASU"…

Day 11

Nurse Manager, Nurses, CCAC representative, social worker are all present, but no physicians again..

Nurse Manager: "Patient x is here for 14 days, been involved with case manager and CMHA, going to transition to Diabetes. Patient l, we need to speak to doctor to see if she needs ECT. Patient o had a weekend pass and went well, so need to speak to the doctor to see if she's a possible discharge since we have 6 patients from EMERG and we're under pressures today. Patient y is on form 1 and we may need to do a referral to home care. It's frustrating with patient b because patient in the CMHA program and family is willing to support but the doctor refused to discharge and wants another week because he wants to make sure the patient has a 24 hour program. Patient A, the doctor would like him to stay here for a week to stabilize but CTO accepted and can't wait. We have 5 admits in EMERG and 2 to be seen still, 3 confirmed for PICU, so there's a lot of pressure to try

and maneuver. Patient d has been here for 51 days, and still has no plan set because the doctor missed the meeting and when the Nurse Manager spoke to him, the doctor said Oh just do whichever plan you think works."

Day 12

CMHA representative, case managers, Nurse Managers and Registered Nurses present.

Nurse says: patient x's daughter is very upset that her mother smokes in the room very frequently. The Nurse spoke to patient but still happens; even though the Nurse said to her she can get charged. It's bad because she's also influenced other patient neighbour who never smoked in her life!

Nurse Manager: Patient y has no housing available and patient wants to stay until she figures out where to go, but we explained she can't do that but will connect her with a case manager to see. EDD is for patient z, we're not sure if it's happening tomorrow so we have to wait for the doctor and he's having his doctor meeting tomorrow. Patient o has been here before, 1 day so far but dealing with same nurse from last time. Patient m, CTO and needs housing, meet with case manager. Long term care won't take him we told the doctor, so he said try ECT, the doctor didn't show up to the meeting and said whatever you guys decide go for it.

Nurse Manager: Dr. A needs to be spoken to, he needs to make a certain decision. Client is here for 61 days. We referred him to Ontario Shores before and declined, now he's on new meds, and after we'll reapply for the referral so Ontario Shores see at least we're trying something or doing something about it.

My thoughts: It's frightening and frustrating to see that doctors i.e. people in charge of making orders do no advocate for the patient. when the nurses can only do so much and the Nurse Manager organized the meeting to figure out a plan with everybody and advocate for this patient, the doctor refused to come and said you guys go ahead with what you think??.. so nurses can only discharge, and the issue is that nurses won't because they know the patient isn't ready to go back into the community when he hasn't had his meeting even. The patient is not being considered at all by this act!

Day 13

There's a sense of frustration in the atmosphere, the doctor and Nurse Managers are running around, talking of patients' plans. The case manager comes in and the nurses, all talking together, some discussing patients, that group is more relaxed, don't know the situation yet with EMERG admits etc. Everyone gathers around patient update board and await the Nurse Manager's arrival. Whose meeting is it today?" a nurse asks everyone else. Another nurse answers it's Dr. C, another nurse says at 9:30 today.

Patient involvement in IPC

Meeting begins. Nurse Managers says, patient x, nurse answers we changed medication and he's responding slowly. Patient y is back, she's bipolar, issue we have so many patients in ECT and the waitlist is until August. Patient z, a nurse says: is very demanding, couldn't walk, almost catatonic. Patient M, the Nurse Manager says: she's out all the time, 44 days almost and the patient thinks we want to throw them out. Who's with her? The Nurse says I am, doesn't need CCAC, daughter is upset but there's no reason to keep her. The doctor says if the daughter doesn't come to get her, we'll send her in a cab to the home. No matter when she'll be discharged, the daughter will complain!

Doctor present says: patient d 44 days, asks everyone on IP team if everybody feels comfortable about his discharge. He went on a weekend pass and it went well, settled down with meds, CT scan getting done because it could've been a possible stroke the previous doctor noted.

Another patient, 9 days and showing very threatening demeanor, "it's my attitude get used to it" when he was warned. We'll see what Ontario Shores has to say after they see what med changes we did. But no need to send another referral to CMHA since patient already well connected to community and lives there and doesn't make sense to keep her in here.

Nurse Manager says, we need Dr. z to come and reassess her, but he's not here, though she has Dr. x who knows her very well but the patient is not in good demeanor so we need to give her a couple of days then we can talk to her.

Nurse Manager says: Doctor p is planning a discharge for patient l. Doctor present answers, he's been discharged! Nurse Manager, ok good!

Nurse Manager: so there're 7 admits in EMERG, fully aware that we can't take into PICU because will make the area more volatile and we can't do that. We have 9 beds available in Peterborough, 3 at the Scarborough Grace Birchmount location. Doctor present answers: so we can talk to crisis then and let them know if we have to send them we have to send them.

Day 14

Durham Mental Health, CMHA, Nurse Manager and Nurses present. Also, physician present but not within group. He's talking to a student in one end of the room, then left soon after 2 min of the meeting. Didn't seem to have come for the IPC meeting!

Nurse Manager goes down list of patients with Nurses, patient a is going to be discharged today. Patient b has very good eye contact, clean and responsive. Patient c, wife is upset he's losing fast, last week the patient wasn't doing well and the pass didn't

go well. Patient d, need to get doctor here, she needs to be looked at for a possible discharge. Patient f, do we know if she's finished ECT? The doctor needs to see her every day and plan a discharge. Patient f, case manager says we have a referral put in for Act but patient not even open to ACT, so maybe I'll have to reassess. He did have a case manager before but patient seems to not remain.

Nurse Manager communicates to Charge Nurse results from the EMERG meeting with doctor x and y re assessing everything from EMERG. Nurse Manager says, patient g has a place to stay on his own, he's up and about and can't wait here for 1-2 years until finds housing. Has to be realistic because he just doesn't want to do anything and want us to take care of everything for him.

Doctor (also Charge Physician) comes to the meeting at 9:15. The Nurse Manager asks him, we have constant observations of 2 patients since last week, have no idea if we need to continue. A second patient in room 29 has everything hooked up and belongs to schizophrenic site

Doctor says: it's clear the other doctor is not communicating and nothing is on the chart!

Day 15

Meeting has CMHA member, case manager from Pinewood addiction center, Nurses, Nurse Managers. Nurse Manager begins,19 year old with depression, it's a patient of doctor x so we got to get on it. Another patient, I'm just concerned as he's discharged, what support is the wife going to have, he became so catatonic here and wife is not used to that. Maybe we need a CCAC referral. For patient x, patient is under impression he's going to be discharged but referred to Ontario Shores and they accepted him, as well as EPI so he needs to know.

Patient z, family feels they need more support, family meeting coincides with doctor's meeting the Nurse says "I left him a note and he hasn't responded so if anyone sees him, please ask him to see me."

Patient y, he drinks and overdoses because he's lonely, pressured so I'm going to look into hooking him up with case management.

Patient n, went on a weekend pass so the doctor needs to review her discharge planning. For patient o, doctor thinks ECT is a solution possibly, but family doesn't want that so we're having a family meeting.

Nurse Manager says, we have 1 admission from EMERG into PICU, so it's a good day especially that all partners are present.

My thoughts: Nurse manager is very patient focussed, genuinely concerned about what happens to patient after discharge and who will take care of them, what resources are available etc. from my conversation with the Nurse Manager about an 18 year old patient that's not responsive to treatments because that age group is primarily concerned with stigma and being labelled as a mental health patient. They're already dealing with lots of issues transitioning into adulthood so all they want is to be discharged and so their illness gets accumulated over time.

Day 16

Nurse Manager, 3 Nurses, Durham Mental Health, case manager

Nurse Manager: patient x, is she due for a discharge?

Case manager: we'll have to talk to doctor because he usually discharges on Thursdays. But the patient declined the Mental Health Day Treatment and wishes to continue with her own personal psychologist.

Patient y, Nurse says: we put in a referral for CCAC to see if his home is appropriate environment. His wife says he's not sleeping, so maybe we need to reassess him, maybe sleeping medication will help.

Patient z, nurse says patient is seen by DMH and Pinewood and needs to follow-up today for discharge.

Patient m, nurse says she's got a family meeting this Friday, she's disrespectful or acts but she'll be kicked out

Patient n, nurse says this patient has surgery tomorrow, doesn't know if she needs a 24 hr stay at surgery or what the surgery this is exactly. Nurse Manager says to nurse, ok I'll follow-up with bed meeting.

3 more nurses joined the meeting.

Day 17

Nurse Manager asks, do you have any anticipated discharged today?

Patient m, had an argument with husband, she's mentally ill, crying, not a reason for her to stay. Should be discharged next week and the order goes to the Day Program which we've requested for 16th and 24th.

Patient n is voluntary, been here 40 days, and had review board, she was so sick, schizophrenic.

Patient involvement in IPC

Patient o, during the daytime there's so much stimulation here versus Whitby environment 4th floor locked unit and is so much quieter. Tying her down disturbs her.

Patient p, no privileges after she comes off from form, expires, and sat in crisis bed. She's not ready to move forward, can't live alone and patient doesn't want to do that.

Patient r, is interested in case management the Nurse says.

Patient s, is improving a bit. She's a little bit brighter, dependent but seclusive.

Patient t, supposed to decide on referral within 48 hours but hasn't yet.

Patient u, has a lot of support from family and us, he's very sad and depressed, suicidal, so we need to see what doctor has to say.

APPENDIX C
Interview Scripting

Professionals Interviews:

Key Informant Interviews Script – Statements at beginning of the interview

Hello _____.
Thank you for taking part in our research project titled **"The role of patient involvement in IPC- a catalyst to the delivery of patient-centered care at community based mental health settings"**.
The interview will take 30-60 minutes in length. During the interview, I kindly ask that you refrain from using the names of, or any identifying information of your colleagues, patients, or other individuals.
The interviews will be audiotaped using a digital recorder and will be transcribed for data analysis. The interviews will be coded and all identifying information will be removed. This information will be kept in a separate file from the data and locked in a secure filing cabinet. The data and the consent forms will be kept in a locked file drawer in the Research Supervisor's office. All data will be kept confidential and anonymous.
If during this interview you feel uncomfortable with a question, you have the option of avoiding it and may do so by indicating your choice to the interviewer. If you would like to discontinue your participation in the interview, you may ask the interviewer to do so at any time. Your consent form and any data collected prior to your withdrawal will be shredded and audiotaped records (if any) will be destroyed at the time of your withdrawal.
Once again, thank you very much for your participation. Your contribution will help provide guidance about how to implement interprofessional practice in the delivery of care to mental health patients. Do you have any questions before we begin? Thank you.

1. **What is your understanding of interprofessional care?**

2. **Can patients be part of the IP team? To what extent can they become involved?**

3. **How does interprofessional care function on a large-scale?**

4. **What are your expectations of interprofessional care?**

b) Patient Interviews

Questions were adapted from a Canadian study by Shaw, S. N. (2008) at the Toronto Western Hospital Family Health Centre, as well as from the contextual observations of IPC meetings involving the mental health team.

Patient interviews script as follows:

Hello _____.
Thank you for taking part in our research project studying the role of patients in the delivery of patient-centered care at mental health settings.

The interview will take between 30 to 60 minutes in length. We need your help. Interprofessional Collaboration is defined as health and social care professionals working together with you to provide care. We would like to know your views on interprofessional collaboration.
I kindly ask that you refrain from using the names of, or any identifying information of other individuals.
The interviews will be audiotaped using a digital recorder and will be transcribed for data analysis. All identifying information will be removed. The transcribed record from the interview will be kept in a separate file from the analyzed data and locked in a secure filing cabinet. The data and the consent forms will be kept in a locked file drawer in the Research Supervisor's office. All data will be kept confidential and anonymous.
If during this interview you feel uncomfortable with a question, you have the option of avoiding it and may do so by indicating your choice to the interviewer. If you would like to discontinue your participation in the interview, you may do so at any time. Your consent form and any data collected prior to your withdrawal will be destroyed at the time of the withdrawal.

1. **Tell me about your helpful and/or unhelpful experiences of the interprofessional care you received during your current stay here at the Lakeridge Mental Health Clinic.**
2. **What is your understanding of interprofessional care?**
3. **How does interprofessional care work on a large-scale?**
4. **What are your expectations of interprofessional care?**
5. **What experiences do you wish of interprofessional care?**
6. **Have you been admitted in the mental health clinic here within the past 30 days? For how long did you stay?**
7. **When do you expect to be discharged from the clinic? Are you aware of your discharge plan?**

References

Malhotra N. K. (2006). Questionnaire design and scale development. In: Grover R, Vriens M editor. The Handbook of Marketing Research: Uses, Misuses, and Future Advances. Newbury Park, CA: Sage Publications Inc.; p. 176-202 Chapter 5

Schroder, C., Medves, J., Paterson, M., Byrnes, V., Chapman, C., O'Riordan, A., Kelly, C. (2011). Development and pilot testing of the collaborative practice assessment tool. *Journal of Interprofessional Care, 25*(3), 189-195. doi:10.3109/13561820.2010.532620

Shaw, S. N. (2008). More than one dollop of cortex: Patients' experiences of interprofessional care at an urban family health centre. *Journal of Interprofessional Care, 22*(3), 229-237. doi:10.1080/13561820802054721

Statistics Canada. (2009). *Questionnaire Design*. Retrieved from http://www.statcan.gc.ca/pub/12-539-x/2009001/design-conception-eng.htm

APPENDIX D
Modified CPAT Questionnaire

Thesis Title: Patient involvement in IPC- a catalyst to the delivery of patient-centered care at community based mental health settings

Questionnaire

By May Helfawi

University of Ontario Institute of Technology

The Collaborative Practice Assessment Test (CPAT) includes nine domains: missions and goals, general relationships, team leadership, general role responsibilities, communication, community linkages, decision-making and conflict management, perceived effectiveness and patient involvement (Schroder et al, 2011). Respondents are asked to rate their level of agreement with each of the 57 statements along a seven-point scale ranging from the lowest value of 'Strongly Disagree' to the highest value of 'Strongly Agree', and answer additional open-ended questions (Schroder et al, 2011). The purpose of the questionnaire is to measure the professional's perceptions of IPC, leadership, communication, as well as community and patient involvement in the process of IPC. These four domains are directly correlated with the variables specified for this study. Hence, the questionnaire has been shortened to 23 questions to increase participation rate, and refocus on the questions that are relevant to this research project. The categories were chosen based on contextual observations of interprofessional collaborative (IPC) meetings at Lakeridge Health twice a week during the months of May to July 2012. These meetings take place at the Lakeridge Health Oshawa to gather all professionals and discuss patient treatment interventions and discharge plans. The purpose of the observations is to understand nature of interactions amongst professionals as well as investigate evidence of patient involvement in the decision-making process of treatment interventions and discharge planning. Observations will also aid in identifying key informants for the interviews that will take place post questionnaire collection.

The Principal Investigator, Helfawi, has been attending two daily IPC meetings, both of which involve the mental health team. The first morning meeting takes place at

Patient involvement in IPC

8:30am at the Emergency Department, and involves social workers, nurses, social workers, a physician, community partners from Durham Mental Health Association (DMHA) and Canadian Mental Health Association (CMHA) as well as the patient care manager of the mental health clinic. This meeting mainly takes place to update the IPC team at EMERG with vacancy at the mental health clinic, number of beds currently occupied, as well as any potential discharges planned thereby creating vacancy for new admissions seen by the EMERG team. The second IPC meeting takes place at the mental health clinic at 8:50am, and involves the same staff aforementioned as well as the remaining group of nurses and the mental health team members. This meeting involves discussion of each inpatient conditions, treatments and subsequent discharge plans. The patient care manager who leads this IPC meeting also communicates all patient cases to be admitted into the mental health clinic as discussed at the previous 8:30am IPC meeting.

The questionnaire distributed to the interprofessional team at the mental health clinic asks the individual to rate each of the 23 statements along a seven-point scale ranging from the lowest value of 'Strongly Disagree' to the highest value of 'Strongly Agree'. The individual is instructed to place a number next to each statement corresponding to their response.

1- **Strongly disagree**
2- **Mostly disagree**
3- **Somewhat disagree**
4- **Neither agree/disagree**
5- **Somewhat agree**

Patient involvement in IPC

6- Mostly agree

7- Strongly agree

Statements:

☐ 1. All team members are committed to collaborative practice.

☐ 2. Members of our team have a good understanding of patient/client care plans and treatment goals.

☐ 3. Patient/client care plans and treatment goals incorporate best practice guidelines from multiple professions.

☐ 4. There is a real desire among team members to work collaboratively.

☐ 5. Team members respect each others' roles and expertise.

☐ 6. Our team leader is out of touch with team members' concerns and perceptions.

☐ 7. Team members negotiate the role they want to take in developing and implementing the patient/client care plan.

☐ 8. Physicians usually ask other team members for opinions about patient/client care.

☐ 9. Team members are held accountable for their work.

☐ 10. Team members feel comfortable advocating for the patient/client.

☐ 11. Patients/clients concerns are addressed effectively through regular team meetings and discussion.

☐ 12. Our team has developed effective communication strategies to share patient/client treatment goals and outcomes of care.

☐ 13. Our team meetings provide an open, comfortable, safe place to discuss concerns.

☐ 14. Patient/client appointments are coordinated so they can see multiple providers in a single visit.

Patient involvement in IPC

☐ 15. On our team the final decision in patient/client care rests with the physician.

☐ 16. Our team has a process to optimize the coordination of patient/client care with community service agencies.

☐ 17. Members of our team share information relating to community resources

☐ 18. Our team has established partnerships with community organizations to support better patient/client outcomes.

☐ 19. Team members encourage patients/clients to be active participants in care decisions.

☐ 20. Team members meet face-to-face with patients cared for by the team.

☐ 21. Information relevant to healthcare planning is shared with the patient.

☐ 22. The patient/client is considered a member of their healthcare team.

☐ 23. Patients/clients family and supports are included in care planning, at the patient's request.

<u>Open ended questions:</u>

1. **What does patient-centred care mean to you? Who does it include?**

_____

_____

_____

2. **How does your clinic advocate for patient involvement in treatments and in discharge planning, and why?**

_____

_____

3. **Can patients become part of the interprofessional team, and why?**

References

Schroder, C., Medves, J., Paterson, M., Byrnes, V., Chapman, C., O'Riordan, A., Kelly, C. (2011). Development and pilot testing of the collaborative practice assessment tool. *Journal of Interprofessional Care, 25*(3), 189-195. doi:10.3109/13561820.2010.532620

Shaw, S. N. (2008). More than one dollop of cortex: Patients' experiences of interprofessional care at an urban family health centre. *Journal of Interprofessional Care, 22*(3), 229-237. doi:10.1080/13561820802054721

APPENDIX E
IPC Poster

APPENDIX F
Professionals Consent Forms

August 7, 2012

Patient involvement in IPC, a catalyst to the delivery of patient centred-care at community based mental health settings

Dear participant,

As you are a practicing healthcare or social worker at the mental health clinic of Lakeridge health Oshawa, you are invited to participate in an evaluative study to examine the extent to which patients contribute to interprofessional care as well as the delivery of patient centered care. This study has been reviewed and received ethics clearance through the Research Ethics Board at the University Of Ontario Institute Of Technology (File # REB) and from the Scientific and Ethics Review Committee of Lakeridge Health. The investigator group for this project includes:

Principal Investigator:
May Helfawi, B.Sc.(Hon), Master of Health Sciences Candidate, Faculty of Health Sciences, University of Ontario Institute of Technology, 2000 Simcoe St. North, Oshawa, ON; L1H 7K4
may.helfawi@uoit.ca, 905-721-8668 ext. 2934
Research Supervisor:
Brenda J. Gamble, Ph.D., Assistant Professor, Faculty of Health Sciences, University of Ontario Institute of Technology, 2000 Simcoe St. North, Oshawa, ON; L1H 7K4
brenda.gamble@uoit.ca, (905) 721-8668 ext. 2934

Purpose of the Research:

Interprofessional collaboration (IPC) practice has been increasingly considered in healthcare, as it is believed to improve patient care and safety, promote greater acceptance of treatment, and increase patient satisfaction. Although IPC is increasingly linked to patient-centred care, the role of patients in the collaborative process is not clear in the literature to date. The purpose of this study is to explore the patient-centred experience and how the dynamic of patient involvement works with respect to IPC. Your participation is fundamental to our project because you are a practicing social or healthcare professional in Ontario, and are involved in the process of IPC at the Mental Health clinic at Lakeridge Health.

Participation

Your participation in this study initially requires that you fill out the questionnaire attached to this letter, and return it to the Principal Investigator (Helfawi) in the envelope enclosed. This should take you no more than 20 minutes to complete.

Second, if you're interested you can choose to be interviewed with the Principal Investigator to obtain your views on how IPC advocates for patient-centred care at community based mental health settings.

The interview will take between 30-60 minutes in length. The interviews will be audio-taped and transcribed. Only the interviewer will be able to identify you. The interviewer and transcriber is the same person (Helfawi). Once the interview has been completed, the audio-tape and any written information from the audio-tape will be kept in a locked, safe place and your name will not be marked on either the tape or any paper material. If you prefer not to be audio-taped, we will take detailed notes of the discussion instead. Your contribution will remain strictly confidential.

Potential Harms:

There are no harms associated with your participation in this project.
If you experience stress or anxiety during the interview, we can stop the interview. You may also contact the social worker at 905-576-8711.

Potential Benefit to Individual Subjects:

Your participation will give you the ability to make your views known, provide relevant observations of the impact of patient involvement from the practitioner's point of view, and articulate potential improvements in the delivery of patient centered care that may not have been considered previously.

Confidentiality:

We strongly respect your privacy. No information about you or your practice will be given to anyone or be published without your permission, unless required by Law and the court orders us to give them a copy of our study papers. You will be contacted for permission upon needing this data to be used for secondary projects. The data produced from this study will all be assigned random nicknames rather than personal names. The data will be stored in a secure, locked location, and only research team members will gain access to this data. Following completion of this study, the data will be kept for seven years as required, then destroyed immediately as per the Faculty of Health Sciences policy at University of Ontario Institute of Technology. Published study reports will not in any way reveal your identity.

Voluntary Participation:

Participation in this study is voluntary. By participating in this study you are not waiving your legal rights. You are free to withdraw from the study at any time during the study period. Any information already provided by you prior to withdrawing will not be used in the study and will be permanently destroyed. New information that we get while we are doing this study may affect your decision to take part in this study. If this happens, we will tell you about this new information. And we will ask you again if you still want to be in the study.

Publication of Results:

Upon completion of the project in approximately one year, findings of the study may be presented to the inter-disciplinary meeting team at Lakeridge Health Oshawa. Findings will be displayed in

a poster at the Mental Health Unit Conference room. The poster will also have an invitation for you to attend an academic publication at the University of Ontario Institute of Technology.

Consent:

"By signing this form, I agree that:

1) You have explained this study to me, and any possible benefits and harms (if any).
2) I have read and understood the relevant information.
3) I understand that I have the right to choose to participate or not participate in this study, and my decision will not affect my employment status.
4) I am free to ask any questions now and in the future.
5) I understand that no information about my identity will be given to anyone or be published in any form.

6) I have read and understood pages 1 to 3 of this consent form, and I agree to participate in this research project. Please indicate by checking the appropriate box, the parts that you agree to participate:

   ☐ Questionnaire. Please complete attached questionnaire.

   ☐ Interview with audio-taping

   ☐ Interview without audio-taping

_____ _____

Printed Name of Subject Subject's signature & date

Enclosed here is a second copy of this consent form that you can keep for your record. If you have any further questions about this study, please contact May Helfawi or Dr. Brenda Gamble at 905-721-8668 Extension: 2934, or email (may.helfawi@uoit.ca).

If you have any questions regarding your rights as a research participant, please do not hesitate to contact the University of Ontario Institute of Technology Compliance Officer at 905-721-8668 Extension 3693, (compliance@uoit.ca), or you may contact the Chair of Research Ethics Board at Lakeridge Health at (905) 576-8711.

Your participation in this research is greatly appreciated.

Sincerely,

May Helfawi

May Helfawi, BSc (Hon)
Master of Health Sciences Candidate
University of Ontario Institute of Technology

APPENDIX G

Table 4-13: Observation Chart from Daily IPC Meetings at the Mental Health Unit.

	Physician present	Community partner involvement	Discharge focus	Open communication	Patient/family involvement	Length of Stay
1	*Y*	*Y*	*Y*	*No- doctor doesn't want to discharge a patient team believes is ready*		*Y*
2	*N*	*Y*		*Yes, "story of patient" is discussed*	*Y- patient's being receptive to treatment and family is cooperating and understanding -Talks of involving patient and mother*	*Y- talks of losing patient bed and transfer to consider alternate accommodations and/or outpatient treatment facilities*
3	*N*	*Y*	*N*	*Y- everyone contributes to discussion, open and comfortable discussions about treatment and patient cases*	*Y- I'll check with patient to see if they're aware if their meeting with Dr*	*Y*
4	*N*				*Y- Choice to make as an adult, doctor said to patient*	
5	*N*	*Y*	*Y- pressure to discharge and decrease length of stay*	*Y- community members and social workers having open discussion of options for patients*		*Y- talks about number of beds available and each patient's LOS*
6	*N*	*Y*	-	*Y- doctor's psychiatric assessment needed for patient's referral but is not done.*	-	-
7	*N- need for physician to finalize discharge plans, confirm*	*Y*	*Y- don't know what the plan is for discharge by not having*	*Y- Nurse Managers communicating number of admits from EMERG with team and*	*Y- talks of patient and family meeting to explain meds/ referrals -Patient's mom keeps calling*	*Y- patient for 13 days and supposed to have gone yesterday,*

	treatments and progress		*physician present -physicians always discharge on Fridays*	*discussing openly each case -Social workers and community partners involved with patient meetings and educating them about illness/ referrals*		*but still here. Another patient also 13 days but will be discharged by end of week.*
8	*Y- came in late to meeting but talked to board with patients, knowledge able and aware of his patients' situations,*	*Y*	*Y- doctor confirmed meeting to be scheduled with patient and family to discuss*	*Y- discussions of patient treatments, length of stay and discharge plans/meetings between the physician and social workers and nurses*	*Y- meeting with doctor and discussing referrals*	-
9	*N*	*Y- discussion of supports in community and referrals in place*	*Y- can send patient home can continue medication there and doesn't need to be here*	*Y- but absence of physician affects discharge decisions and "slows process down" as Nurse Manager said. "It's very physician driven process when Nurse Managers are the ones responsible for discharge numbers"*	*Y- patient likes routines and may not like movement, another patient is aware of discharge and ready to go*	*Y- patient referral to Ontario Shores declined and still here, move to RASU*
10	*N*	*N- but a social worker is present with Nurses and Nurse Manager*	*Y- but stressed because can't finalize when physician is absent*	*N/A- not enough staff to discuss patient treatment plans/discharge, no social worker, no physician present, just nurses .*	*Y- need to follow-up with doctor to see how meeting went*	-
11	*N*	*Y*	*Y- 6 admits from EMERG and no doctor to confirm discharges to make availability*	*Y- disagreement with physician refusing to discharge when patient has community and family support available*	*Y- talks of family support with patient and programs/community resources if available*	*Y- concerned with patient's LOS of 13 days and went on weekend pass. Another*

						patient was at Unit for 51 days and still has no plan set because physician missed the meeting.
12	*N*	*Y*	*Y- physician in charge of making orders but*	*Y- frustration with absence of physician, missed meeting with patient*	*Y- daughter of patient is upset mother took up smoking because of room-mate. Questioning advocacy of patient when doctor tells nurses to do whatever they see fit with discharge orders*	*Y- same concern with patient for 61 days*
13	*Y*	*Y*	*N*	*y- Doctor and Nurse Managers a bit frustrated with EMERG admits of 7 but fully aware no space in PICU, so they decide patients to transfer to other hospitals with PICU beds availability.* *- but complete team present eases communication, after meeting went smoothly and open discussion: doctor asks IP team members input if everybody is comfortable with discharge decisions.*	*Y- daughter unhappy and opposing to discharge of mom but doctor persists ok to discharge*	*Y- patient there for 44 days, had a weekend pass and is settled with meds, and ready to discharge, another for 9 days but has good community connections and no need to stay at Unit*
14	*N- Charge Physician came in to see no physicians present and expressed*	*Y*	*Y- absence of physician again delays discharge process*	*Y-*	*Y- talks about patient responsiveness, weekend pass status, referrals in place. Housing issue comes up as a concern for*	*Y- patient has a place to stay on his own, doctor says: "can't wait here 1-2 years until*

	it's clear they're not here to communic ate about their patients at the IP meeting and can't update chart				*patient who didn't want to be discharged*	*he gets housing"*
15	*N*	*Y -CMHA rep left a note for physician about patient but hasn't got a response*	*N- not much focus on discharge, Nurse Manager says "it's a good day with 1 admit from EMERG, and especially all partners are present"*	*Y- Nurse Manager patient focussed and concerned with what happens to patient post discharge, open discussion with referrals set up and partner engagement.*	*Y- concerns about what support available for patients post discharge, and support for the wife . talks about patients feelings, and setting up family meetings and/or referrals with case management.*	-
16	*N*	*Y*	*Y- "is patient due for discharge" Nurse Manager asks, Nurse says about another patient "I need to follow-up today for discharge" with community partner referral placed*	*Y- but absence of physician delays discharge/ treatment decisions.*	*Y- team discussing appropriate environment for patients, talk to wife about sleeping well, maybe change medication and reassessment needed by physician, and follow-up with bed meetings for patient transfer to outpatient facility (surgical unit)*	-
17	*N*		*Y- Nurse Manager asks: "do we have any anticipated discharges today?"*	*Y- everybody on team is involved in discussion patient updates*	*Y- discussions around patients privileges and coming off form, patient has lots of family support but doctor says , patients interested in case management*	*Y- voluntary patient here for 40 days, patient had argument with husband, crying but not a reason to stay*

APPENDIX H
Patient Confidentiality Form

Patient Confidentiality Agreement

- Title of Research Project: Patient involvement in IPC, a catalyst to the delivery of patient centred-care at community based mental health settings.

- Student Investigator: May Helfawi, HBSc, MHSc Candidate
  Faculty Supervisor: Dr. Brenda Gamble, PhD
  Lakeridge Health Supervisor: Ted Sellers

- "By signing this form, I agree that:

  1) Patient privacy is strongly respected. No information about any patient will be given to anyone or be published without their permission. Patients will be contacted for permission upon needing this data to be used for secondary projects.

  2) The data produced from this study will all be assigned numerical labels rather than personal names. The data will be stored in a secure, locked location, and only research team members will gain access to this data.

  3) Following completion of this study, the data will be kept locked in a filing cabinet at the Research Faculty Supervisor's office at UOIT for seven years as required, then destroyed immediately as per the Faculty of Health Sciences policy at UOIT. Published study reports will not in any way reveal patient identity.

_____
Printed name of thesis committee member

_____

Signature & date

APPENDIX I
Patient Consent Forms

August 7, 2012

Patient involvement in IPC, a catalyst to the delivery of patient centred-care at community based mental health settings

Dear participant,

As you are a patient at the mental health clinic of Lakeridge health, you are invited to participate in a study of the role of patients in the delivery of care at mental health settings. This study has been reviewed and received ethics clearance through the Research Ethics Board at the University Of Ontario Institute Of Technology (File # 12-014) and from the Scientific and Ethics Review Committee of Lakeridge Health. The investigator group for this project includes:

Principal Investigator:
May Helfawi, B.Sc.(Hon), Master of Health Sciences Candidate, Faculty of Health Sciences, University of Ontario Institute of Technology, 2000 Simcoe St. North, Oshawa, ON; L1H 7K4
may.helfawi@uoit.ca, 905-721-8668 ext. 2934
Research Supervisor:
Brenda J. Gamble, Ph.D., Assistant Professor, Faculty of Health Sciences, University of Ontario Institute of Technology, 2000 Simcoe St. North, Oshawa, ON; L1H 7K4
brenda.gamble@uoit.ca, (905) 721-8668 ext. 2934

Purpose of the Research:

Interprofessional collaboration (IPC) practice has been increasingly considered in healthcare, as it is believed to improve patient care and safety, and increase patient satisfaction. The purpose of this study is to explore the patient-centered experience. Your participation is important to our project to determine the extent to which you are involved in the process of IPC and delivery of patient care.

Participation:

Participation in this research requires that you participate in individual interviews conducted in person. The purpose of this interview is to obtain your views on how social and healthcare professionals work together with you to deliver the best care and recovery plan.

The interview will take between 30 to 60 minutes in length. We will contact you to set up the day and the time of the interview according to your preference. The interviews will be audio-taped and transcribed. Only the interviewer will be able to identify you. The interviewer and transcriber is the same person (Helfawi). Once the interview has been completed the audio-tape and any written information from the audio-tape will be kept in a locked, safe place and your name will

not be marked on either the tape or any paper material. If you prefer not to be audio taped we will take detailed notes of the discussion. Your contribution will remain strictly confidential, and you will not be identified in any of our reports or publications.

Potential Harms:

There are no harms associated with your participation in this project.

Potential Discomfort:

Certain people may experience a slight discomfort or anxiety when answering questions in an interview. If you experience stress or anxiety during the interview, we can stop the interview. You may also contact the social worker at 905-576-8711.

Potential Benefit to Individual Subjects:

Your participation will give you the ability to make your views known to the hospital, and your observations can help improve the delivery of patient care at Lakeridge Health and other mental health settings.

Potential Benefit to Society:

This study will provide guidance on how to implement interprofessional practice in the delivery of decision support to mental health patients.

Confidentiality:

We strongly respect your privacy.

1. Your personal name will not be given to anyone, and no information about you will be published without your permission, unless required by law; for example, if the court orders us to give them the study papers.
2. The hospital and your physician will never see your responses to this interview and will not have access to this data.
3. You will be contacted for permission upon needing this data to be used for secondary projects.
4. The list of names produced by Sellers will be stored at a locked drawer at Sellers' office, at Lakeridge Health.
5. Data produced from your interview will all not be assigned personal names, but randomly labelled "patient one," "patient two," …etc. This list will be kept separately with Helfawi, to which Sellers and your physician will not have access to.
    - Hard copies of this data will be stored in a secure, locked location at the office of the faculty supervisor at UOIT.
    - Soft copies will be kept on a password protected computer which also will be stored in UOIT to which only Helfawi has access to this password.
    - Following completion of this study, the data will be kept for seven years as required, then destroyed immediately as per the Faculty of Health Sciences policy at UOIT. Published study reports will not in any way reveal your name or identity.

Voluntary Participation:

Participation in this study is voluntary, and your decision to participate will not affect your care or treatment at the hospital. You may ask any questions or speak to anyone you wish (physician, family, etc.) to help you decide if you would like to participate in the study. By participating in this study you are not waiving your legal rights. You are free to withdraw from the study at any time during the study period. You may wish to withdraw after completion of the study, and may do so by informing Ted Sellers at the mental health clinic. Any information already provided by you prior to withdrawing will not be used in the study and will be permanently destroyed. New information that we get while we are doing this study may affect your decision to take part in this study. If this happens, we will tell you about this new information. And we will ask you again if you still want to be in the study. We assure you that your decision to continue or discontinue with the study will in no way affect your care process.

Publication of Results:

Upon completion of the project in approximately one year, findings of the study will be displayed in a poster at the Mental Health Unit Conference room.

Consent:

"By signing this form, I agree that:

7) You have explained this study to me, and any possible benefits and harms (if any).
8) I have read and understood the relevant information.
9) I understand that I have the right to choose to participate or not participate in this study, and my decision will not affect my healthcare process.
10) I am free to ask any questions now and in the future.
11) I understand that no information about my identity will be given to anyone or be published in any form.
12) I have read and understood pages 1 to 3 of this consent form. I agree to partake in this research study. Please indicate by checking the appropriate box, the parts that you agree to participate:

- ☐ Interview with audio-taping
- ☐ Interview without audio-taping

_____

Printed Name of Subject

_____

Subject's signature & date

Enclosed here is a second copy of this consent form that you can keep for your record. If you have any further questions about this study, please contact May Helfawi or Dr. Brenda Gamble at 905-721-8668 Extension: 2934, or email (may.helfawi@uoit.ca)

If you have any questions regarding your rights as a research participant, please do not hesitate to contact the University of Ontario Institute of Technology Compliance Officer at 905-721-8668 Extension 3693, (compliance@uoit.ca), or you may contact Nicole Stevens, the Chair of Research Ethics Board at Lakeridge Health at (905) 576-8711.

Your participation in this research is greatly appreciated.

Sincerely,

May Helfawi

May Helfawi, BSc (Hon)
Master of Health Sciences Candidate
University of Ontario Institute of Technology

APPENDIX J
RA Patient Confidentiality Agreement

Coding Confidentiality Agreement

- **Project Title: Patient involvement in IPC, a catalyst to the delivery of patient centered-care at community based mental health settings**

- Principal Investigator: May Helfawi, HBSc, MHSc Candidate
  Faculty Supervisor: Dr. Brenda Gamble, PhD

- By signing this form I, _____,
  agree to:

1) Keep all the research information asked to code confidential and not discuss or share this research information with anyone other than the Principal Investigator and Faculty Supervisor;
2) Keep all research information in any form or format secure while it is in my possession;
3) Return all research information in any form or format to the Principal Investigator when I have completed the research tasks;
4) Erase and/or destroy all research information in any form or format regarding this research project that is not returnable to the Principal Investigator, and after consulting with the Principal Investigator.

Research Assistant:

_____	_____	_____
(Print name)	(Signature)	(Date)

Principal Investigator:

_____	_____	_____
(Print name)	(Signature)	(Date)

If you have any questions or concerns about this study, please contact:
May Helfawi at may.helfawi@uoit.ca

This study has been reviewed and approved by the Research Ethics Board at University of Ontario Institute of Technology.

APPENDIX K
Audio taping Consent Form

Title of Research Project:
Patient involvement in IPC, a catalyst to the delivery of patient centred-care at community based mental health settings

Investigator(s):

Principal Investigator:
May Helfawi, B.Sc.(Hon), Master of Health Sciences Candidate
Faculty of Health Sciences
University of Ontario Institute of Technology
2000 Simcoe St. North
Oshawa, ON; L1H 7K4
(647) 887-7017
may.helfawi@uoit.ca

Research Supervisor:
Brenda J. Gamble, Ph.D., Assistant Professor
Faculty of Health Sciences
University of Ontario Institute of Technology
2000 Simcoe St. North
Oshawa, ON; L1H 7K4
(905) 721-8668
brenda.gamble@uoit.ca

Confidentiality:
The audiotapes produced from this study will be stored in a secure, locked location. Only members of the research team will have access to them. Following completion of the study the digital recordings will be deleted permanently.

***Consent*:**
By signing this form,

1) I also agree to be audio taped during this study. These tapes from this one interview session will be used to assist with transcription of important information that will be discussed in the interview.
2) I understand that I have the right to refuse to take part in this study. I also have the right to withdraw from this part of the study at any time. eg., before or after the recordings.
3) I am free now, and in the future, to ask questions about the taping.
4) I have been told that my transcripts will be kept private. You will give no one any information about me, unless the law requires you to.
5) I understand that no information about me (including these tapes) will be given to anyone or be published without first asking my permission.
6) I have read and understood pages 1 to 2 of this consent form. I agree, or consent, to having my voice being taped (in person and on telephone) as part of the study.

Patient involvement in IPC

_____ _____

Printed Name of Subject Subject's Signature & date

_____ _____

Printed Name of person who explained the consent Signature & Date

In addition, I agree or consent for this tape(s) to be used for:
(Please check all that apply)

- O Other studies on the same topic.
- O Teaching and demonstration at UOIT.
- O Teaching and demonstration at meetings outside UOIT.
- O Not to be used for anything else.

In agreeing to the use of the tape(s) for other purposes, I have been offered a chance to hear the tape(s). I also have the right to withdraw my permission for other uses of the tape(s) at any time.

_____ _____

Printed Name of Subject Subject's signature & date

_____ _____

Printed Name of person who explained consent Signature & date

If you have any questions about this study, please call May Helfawi or Brenda Gamble at 905-721-8668 Ext: 2934.

If you have questions about your rights as a subject in a study or injuries during a study, please call the Ethics and Compliance Officer, at 905-721-8668, Ext: 3693.