

santé mentale

Strengthening collaboration through interprofessional education:

A resource for collaborative mental health care educators

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Strengthening collaboration through interprofessional education:

A resource for collaborative mental health care educators

A Toolkit

February 2006

OUR GOAL

The Canadian Collaborative Mental Health Initiative (CCMHI) aims to improve the mental health and well-being of Canadians by enhancing the relationships and improving collaboration among health care providers, consumers, families and caregivers; and improving consumer access to prevention, health promotion, treatment/intervention and rehabilitation services in a primary health care setting.

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Preface

Welcome to the CCMHI Toolkit Series!

The Canadian Collaborative Mental Health Initiative (CCMHI) is led by 12 national organizations representing community services; consumers, families and caregivers; self-help groups; dietitians; family physicians; nurses; occupational therapists; pharmacists; psychiatrists; psychologists; and social workers. Funded through Health Canada's Primary Health Care Transition Fund, the goal of the CCMHI is to improve the mental health and well-being of Canadians by increasing collaboration among primary health care and mental health care providers, consumers, families and caregivers.

The CCMHI toolkits contain practical tools to:

- Assist providers and planners in the implementation of collaborative initiatives.
- Help mental health consumers and their family members understand mental illness and work with other members of the care team.
- Inform educators of the benefits of interprofessional education and provide tools to teach about collaborative mental health care.

Each toolkit was developed with an interprofessional expert panel and guided by a working group representing a number of key stakeholder groups. We hope that readers of any of the toolkits in the series will recommend them to others (e.g., consumers referring toolkits to their providers and vice versa).

In addition to this series of 12 toolkits, the CCMHI has developed a Charter of principles and commitments that will influence the future of mental health care in Canada and a series of reports that capture the current state of collaborative mental health care. The reports highlight health human resource issues, provide an annotated bibliography, summarize best practices, review initiatives from across the nation and summarize provincial and territorial mental health and primary care reform. These documents guided the development of the toolkits and are available at www.ccmhi.ca.

Education toolkit

Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators serves as an educational resource to assist in the implementation of educational initiatives and programs that promote collaborative mental health care in primary health care settings. The toolkit is targeted to education program developers in regulatory agencies, professional associations, regional health authorities, family health teams, governmental departments, and educators within both academic (universities and colleges) and care delivery settings.

This toolkit highlights the importance of interprofessional education in promoting collaborative care. It offers four case studies and several activities accompanied by a

sample lesson plan and other useful tools to aid educators in the implementation of educational events.

Implementation toolkits

Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners is a guide for providers wishing to establish or enhance the mental health services they provide through collaboration. This general toolkit offers readers a guide to all aspects of planning, implementing and evaluating a collaborative mental health care initiative, including assessing need, setting goals and objectives, developing a budget, building a team, maintaining a well-functioning team, managing change and monitoring the initiative.

Eight population-specific toolkits, entitled *Establishing collaborative initiatives between mental health and primary care services*, are designed to be used in conjunction with the general toolkit. They offer tips on adapting the general toolkit for Aboriginal Peoples, children and adolescents, ethnocultural populations, rural and isolated populations, seniors, individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. There is some overlap in the toolkits; for example, information about collaborative mental heath care and the homeless may be found in at least three toolkits: individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. Readers are encouraged to consider all the toolkits that may be relevant to their needs.

The general and population-specific toolkits are not intended as clinical practice guides but offer practical advice on different aspects of establishing successful collaborative initiatives.

Consumer, family and caregiver toolkits

Consumers, families and caregivers developed both of these toolkits for consumers and their loved ones.

Working together towards recovery: Consumers, families, caregivers and providers is intended for all consumers, families and caregivers wishing to know more about mental health and mental illness, how to access services and the type of professionals that can assist them in their recovery. This toolkit also offers an outline of complementary therapies and self-care as well as the contributions and needs of caregivers. Finally, this toolkit includes a guide to "getting involved", describing how government and boards of directors work, and why consumers and families should participate.

Pathways to healing: A mental health guide for First Nations people is a toolkit that offers a basic overview of mental health and mental illness along with a contextual section outlining the impact of history, social, economic and political conditions on the mental health of these peoples. There are tools in this toolkit to foster holistic care.

Introduction

The training and education techniques of health care professionals are key determinants of their willingness to collaborate. In order to assess the prevelance of current Canadian interprofessional education programs that address collaborative mental health care, McVicar et al. (2005) conducted two surveys. Findings at the pre- and post-licensure levels suggest that there is a paucity of programs in this area, prompting the development of this toolkit.



If you are comfortable with the concepts and principles of interprofessional education and collaborative mental health care, you may wish to go directly to *Section B: Implementation*.

Not sure if interprofessional education is right for you? *See Appendix B: Decision Guide.*

The goal of this toolkit is to improve the mental health of people living in Canada by enhancing the interprofessional education and training of key stakeholders. For the purpose of this toolkit, key stakeholders are *not* limited to individuals holding professional designations, and may include: a broad range of primary health and mental health care providers; consumers, families and caregivers; community agencies; prelicensure students; policy makers; administrators; and other individuals who do not necessarily hold a professional designation. Collaboration in the context of collaborative mental health care emphasizes the important role that consumers, families and caregivers have as part of an effective collaborative team.

This toolkit includes:

- 1. A **theoretical section** (Section A) provides background information on the application of interprofessional education within the context of collaborative mental health care.
- 2. An **implementation section** (Section B) provides concrete information and activities to support the implementation of an interprofessional education workshop within the context of collaborative mental health care.
- 3. A **decision guide** (Appendix B) provides questions to help workshop facilitators identify their organization's needs and readiness to engage in an interprofessional education workshop to enhance the delivery of collaborative mental health care in primary health care settings.

How to use the toolkit:

- If you are a general interest reader:
 - Section A provides a brief overview and discussion of the key concepts and principles of interprofessional education, as they relate to the integration of primary health and mental health care.

- If you are a potential workshop facilitator:
 - Section B explains how to organize and facilitate a workshop.
 - A thorough understanding of the contents of Sections A and B is essential to have prior to implementing the workshop.
 - You may consider reading additional materials, depending on your comfort level with the concepts and principles presented in Section A.
- If you are going to be a workshop participant:
 - You may benefit from reading through Section A prior to attending the workshop.
 - You may consider reviewing the activities in Section B.

Why interprofessional education?

Traditionally, health professionals have trained in isolation from other professionals. The curriculum content and structure follow strict disciplinary lines. Students from different professions may have a clinical practicum at the same location, but training schedules, length of time at the location, supervision, and agreements with the academic health centre are all negotiated independently.

A variety of forces are encouraging the move toward interprofessional education. First, students must be able to work as members of a team after graduation. For example, the Royal College of Physicians and Surgeons of Canada has recognized the importance of the role of "collaborator" as a key competency, which all post-graduate residents must demonstrate upon graduation. Second, a number of key reports concerning the Canadian health system have also stressed the need for greater collaboration involving interprofessional teams of health care providers (Kirby, 2002; Romanow, 2002; Health Council of Canada, 2005).

What is collaborative mental health care?

Collaborative mental health care describes a range of models of practice in which consumers and their families and caregivers, together with health care providers from both mental health and primary health care settings—each with different experience, training, knowledge and expertise—work together to promote mental health and provide more coordinated and effective services for individuals with mental health needs.

Similar to engaging in collaborative mental health care activities, opportunities to include consumers, families and caregivers, and other individuals who do not necessarily hold professional designations, should be explored and encouraged when designing, implementing and evaluating interprofessional workshops or programs.

Section A: Background

Unit 1: Interprofessional education in the context of collaborative mental health care

Key Messages: Unit 1

- Collaborative mental health care is one approach to improving the delivery of mental health services in primary health care settings.
- Interprofessional education is a key method of ensuring that various collaborators improve team functioning, for the benefit of the consumer.
- Interprofessional education develops knowledge and understanding of other professions and promotes the respect needed for effective collaboration.

A collaborative practice approach, involving interprofessional teams of health care providers offering comprehensive and coordinated health care services, is one fundamental way to enhance the Canadian health care system (Kirby, 2002; Romanow, 2002; Health Council of Canada, 2005). At the primary health care level, the integration of mental and primary health care is a key



Unit 3: Collaborative Mental Health Care Teams is dedicated to expanding on the benefits of interprofessional approaches to mental health care for all stakeholders, and provides a description of the roles of consumers, families and caregivers, and various team members.

method of ensuring that people living in Canada have access to the mental health care services they need. Approaches to collaborative mental health care bring together a wide range of primary and mental health care providers, consumers, families and caregivers.

The 2003 First Ministers' Accord on Health Care Renewal identified the importance of changing the way health care professionals are educated. *Interprofessional education for collaborative patient-centred practice* was identified both in the Accord and in the 2003 Federal Budget as a means to address current and emerging health and human resource issues. It is also seen as a mechanism to ensure that health care practitioners have the knowledge, skills and attitudes to practice together in an effective collaborative manner (Oandasan and Reeves, 2005a).

Defining interprofessional education

Interprofessional education has been defined as a process by which a group of students/learners (or workers) from health-related occupations, with different educational

backgrounds, learn together during certain periods of their education to improve collaboration and the quality of care (Areskog, 1988; Centre for the Advancement of Interprofessional Education, 1997 revised). The CCMHI defines interprofessional education as "occasions when two or more professions learn from and about each other to improve collaboration and the quality of care."

Interprofessional education may be introduced at two main levels, either pre-licensure or post-licensure. *Pre-licensure* education occurs while a student/learner is in his/her formal years of learning, before receiving a license to practice independently. *Post-licensure* education denotes education that occurs once a health professional is practicing independently. It often takes the form of continuing professional development; however, it could also include graduate education (e.g., Masters of Nursing or Masters of Social Work) (Oandasan and Reeves, 2005a). In the context of collaborative mental health care, interprofessional education activities may also occur formally or informally. Informal activities often occur at the practice level, where the exchange of knowledge between providers and future providers (learners) happens on a regular basis (e.g., informal hallway conversations) (Pauzé, Gagné, and Pautler, 2005).

It should be noted that for the purpose of this toolkit, key stakeholders that ought to be included in the planning, implementation and evaluation of interprofessional education activities extend beyond health care professionals. Key stakeholders may also include: a broad range of primary health and mental health care providers; consumers, families and caregivers; community agencies; pre-licensure students; policy makers; administrators; and other individuals who do not necessarily hold a professional designation. Collaboration in the context of collaborative mental health care emphasizes the important role that consumers, families and caregivers have as part of an effective collaborative team.

Benefits of interprofessional education

"I have a better understanding of roles and will be able to access other people more effectively."

-Workshop participant

It has been reported that interprofessional education results in an increased understanding of the roles, responsibilities, strengths and limitations of other professions (Clark, 1991; Parsell, Spalding and Bligh, 1998; Parsell and Bligh, 1999). The World Health Organization (WHO) (1988) reports that interprofessional education helps to develop mutual respect and understanding between members of the health care team. Other advantages identified by Parsell et al. (1998) and Parsell and Bligh (1999) include:

- improved relationships with other disciplines;
- increased trust:

- dispelled stereotypes; and
- significant improvement in attitudes towards each professional group.

Interprofessional education is also believed to play an important role in supporting and enhancing the collaboration between individuals who are engaged in collaborative mental health care activities (Kates, 2002; Pautler and Gagné, 2005). This includes providing continuing education for existing providers in collaborative care; modifying training programs so that future professionals are knowledgeable in collaborative approaches, styles and skills; promoting collaboration among professional associations, academic faculties and institutions; forming national,

Existing Program

McMaster University (Hamilton, Ontario, Canada) offers a unique component to their "Psychiatry Residency Program" where residents learn to consult and work with primary care practitioners in a "shared care" or collaborative mental health care model.

Both higher education and primary ambulatory care service settings (e.g., family practitioners' offices) are used. Residents have direct and indirect supervision of patient care. The program is 26 weeks in length (75 hours).

regional and local health care policies that support collaboration; funding for collaborative care; and systemic strategic planning (Pautler and Gagné, 2005).

According to Parsell and Bligh (1999) interprofessional education:

- promotes interprofessional collaboration;
- involves interactive learning between professional groups;
- develops knowledge and understanding of other professions;
- encourages professionals to learn with, from and about one another; and,
- respects the integrity and contribution of others.

A key component of effective collaborative mental health care is the richness of

collaboration that occurs between primary and mental health care providers. As noted by Pautler and Gagné (2005), some opportunities to enrich a collaboration include:

- exchange of knowledge between providers about the best practices in mental health care through educational initiatives;
- during schooling courses, lectures, tutorials, seminars, rounds, rotations, case conferences or discussions, committees, placements or locums;

Existing Program

The "Therapeutic Communication" course at Medicine Hat College (Medicine Hat, Alberta, Canada) focuses on developing communication skills and knowledge, and building self-awareness.

Participants in the course come from a broad range of disciplines such as: nursing, occupational therapy, social work and other support specialties (examples included deaf/blind support worker, massage therapist, paramedic, addictions counsellor, and child and youth therapist assistant). The course is 13 weeks in length (39 hours of theory, 39 hours of lab work).

- continuing education: workshops, seminars, symposia or presentations;
- education materials: research papers, studies, books, treatment guides, or manuals;
- involvement of professionals from a wide range of disciplines; and,
- interdisciplinary communication.

Ultimately, the goal is that interprofessional education will lead to improved team functioning and in turn, greater benefits for the consumer. For example, benefits of an effective interprofessional care team (for consumers) include: improved coordination of services; improved integration of care for a range of health needs; involvement of consumers as active partners in their care (Grant et. al., 1995). Benefits of interprofessional team care are discussed in more detail in Unit 3.

Barriers and enablers

Parsell and Bligh (1999) have identified the various barriers to interprofessional education, which have also been supported by a study of interprofessional education initiatives in collaborative mental health care in Canada (McVicar et al., 2005). The following is a summary of the barriers and key enablers, as identified by McVicar et al. (2005):

Pre-licensure

- Top barriers included: problems with schedule/calendar, rigid curriculum, and lack of reward for faculty. Other barriers that were noted were related to: curriculum, time, isolation, administration, attitudes and accreditation and licensing regulations.
- Key enablers included: attitudes, internal and external support/"champions" collaboration and relationship-building, clinical placements and service learning, faculty/teaching, financial support, research on interprofessional education, and other factors related to curriculum, students, requirements of professions, and administration.

Post-licensure

- Top barriers included: turf battles, lack of financial resources and problems with schedule/calendar. Other barriers included: lack of administrative support, accessibility and time constraints, limited resources, limited knowledge base, curriculum constraints, financial limitations, resistance to "buy in" and logistical concerns.
- Key enablers for collaborative training arrangements included: ensuring recognition and respect of all professions, access to time and resources, financial support, interprofessional communication and collaboration, valuing education, leadership support, and research on interprofessional education.

Current programs

"Something I've learned from this programme is that 'disorders, disabilities and difference', which are viewed as weaknesses, inabilities, and abnormalities by society and the ignorant, are not things to be hidden concealed or ashamed of. Hiding them only contributes to that sense of being alien and unaccepted. Knowledge and education erase stereotypes and ignorance."

-Graduate Student

McVicar et al. (2005) conducted two surveys of pre- and post-licensure interprofessional education programs that are specific to collaborative mental health care. The results suggest that the majority of the respondents were not engaged specifically in programs in this area (approximately 64.6 per cent of the pre-licensure and 43.6 per cent of the post-licensure respondents). However, the momentum is growing, since 33.3 per cent and 18.1 per cent of pre- and post-licensure respondents (respectively) indicated their

Existing Program

The "Psychiatric Emergency and Crisis Intervention" course at Memorial University of Newfoundland (St. John's, Newfoundland, Canada) offers training to family medicine residents. The focus is on learning to manage psychiatric emergencies and crisis intervention (32 hours total).

Educators of the course include: family physicians, psychologists, psychiatrists, social workers and legal experts.

involvement in some form of interprofessional education with a collaborative mental health care component. The paper provides a brief summary of 30 programs from across Canada.

At the practice level, Pauzé, Gagné and Pautler (2005) indicate that the majority of current Canadian collaborative mental health care initiatives are engaging in some form pre- or post-licensure interprofessional education. An estimated 13.5 per cent of the initiatives report the involvement of graduate/undergraduate residents/students. In many instances, residents are involved in all aspects of the delivery of care to consumers. In addition, the following methods were used to facilitate knowledge exchange between collaborative team members: dissemination of materials, interactive sessions or joint consultations. The most common method for knowledge exchange involved interactive sessions (82 per cent), including: weekly/monthly meetings, informal case discussions, educational workshops, conferences, or teleconferences. Pauzé and Gagné (2005) provide descriptions of the activities of more than 90 Canadian collaborative mental health care initiatives.



Unit 2: Best practices for interprofessional education

Key Messages: Unit 2

Successful interprofessional education requires:

- collaborative planning from all key stakeholders involved;
- commitment from all key stakeholders;
- a focus on enhancing the knowledge, skills and attitudes of learners to become collaborative practitioners and team members; and,
- the involvement of consumers, families and caregivers, and other key stakeholders in the planning, implementation, and evaluation phases.

Competencies for interprofessional education

Interprofessional education is not an end in itself, but a means of preparing different types of health care personnel, and consumers, families and caregivers, to work together. Interaction is an important element of interprofessional education—interaction between learners and educators from different health care professions. The learner's readiness for interprofessional collaborative practice is influenced by the development of certain competencies. Table 1 outlines a number of interprofessional education competencies representing specific knowledge, skills and attitudinal domains that have been identified by Barr (1998).

Table 1: Collaborative Competencies for Interprofessional Education

- 1. Describe one's role and responsibilities clearly to other professions.
- 2. Recognize and observe the constraints of one's role, responsibilities and competence, yet perceive needs in a wider framework.
- 3. Recognize and respect the roles, responsibilities and competence of other professions in relation to one's own.
- 4. Work with other professions to effect change and resolve conflict in the provision of care and treatment.
- 5. Work with others to assess, plan, provide and review care for individual patients.
- 6. Tolerate differences, misunderstandings and shortcomings in other professions.
- 7. Facilitate interprofessional case conferences, team meetings, etc.
- 8. Enter into interdependent relationships with other professions.

Note: This table was adapted from Barr (1998, p.181) as cited in Oandasan and Reeves (2005a).

Planning for interprofessional education

Oandasan and Reeves (2005b) report that organizing interprofessional education can be a difficult task to achieve due to numerous administrative or logistical obstacles. In particular, the organization of pre-licensure courses across health professional programs involves overcoming "internal inhibitors" such as inequalities in the number of students, geographical isolation from one another, and differences in curricula, including timetable conflicts (Pirrie et al., 1998). Nonetheless, the way in which interprofessional education planning and organization is approached is an important determinant of its success.

According to Nasmith et al. (2003), an important first step in planning a program is to identify key partners of the initiative and involve them in planning and implementation from the very beginning (see Table 2 for additional consideration). Key partners will vary depending on the needs and goals of a given organization/group, but may include:

- Consumers, families and caregivers these individuals offer important and unique perspectives, skills and expertise.
- Health professionals includes all of the professionals who will be collaborating.
- Senior administrators of academic institutions they can implement changes in course structures, foster faculty support through academic incentives, provide funding to support interprofessional education and have a major role to play in the long-term sustainability of initiatives (Curran, Deacon and Fleet, 2005).
- Professional associations, accrediting bodies of continuing professional education, and staff educators with health authorities or other organizational development units within employer organizations. Accreditation partners are particularly important for programs that target health professions, and for whom mandatory continuing professional education is a requirement for re-certification or re-licensure (Curran, Deacon and Fleet, 2004).
- Institutional and political leaders Gilbert (2005, p.101) suggests that "every health and human service program must ultimately recognize that interprofessional education forms a small yet permanent part of its curriculum, that it is not an add-on but an integral and necessary component in the education of health and human service professionals, regardless of discipline."

Existing Program

The continuing medical education course "Psychiatry for Family Physicians" is offered by McMaster University (Hamilton, Ontario, Canada).

The course is 10 months in length (20 hours) and targets family physicians in the community. The course uses a problembased learning format.

"I would encourage others who have a disability or illness to participate in this or a similar programme. For me, it was empowering and enlightening, and gave me a chance to help educate those who may someday be helping me."

-Consumer Educator

Table 2: Key Issues in Planning Interprofessional Education/Collaborative Practice Initiatives

- 1. What are the external/internal drivers influencing the development of this program?
- 2. Who are your potential partners?
- 3. What is the *overall goal* of this activity at the interprofessional and profession-specific levels?
- 4. What are the opportunities within the current learning context?
 - within the patient population
 - in the practice site(s)
 - with the learners in terms of disciplines and level of training
 - in the timing (scheduling, length of program)
- 5. What barriers/difficulties do you anticipate and how can you overcome them?
- 6. Who are the *key players* in designing this intervention?
 - how will you involve them?
 - what will be their roles and responsibilities?
 - how will you build group trust and cohesiveness
 - how will you ensure good communication?
 - how will you resolve conflict?
- 7. What are the specific objectives of this activity?
 - content
 - essential elements of interprofessionalism
- 8. What teaching methods and tools will you use to opertionalize these objectives?
- 9. How will you evaluate this activity?
 - reaction/satisfaction
 - learning (knowledge, attitudes, skills)
 - behaviours
 - results (impact)
- 10. How will you ensure the sustainability of this program?
 - funding
 - challenging the culture

Note: This table was adapted from Nasmith et al. (2003) as cited in Oandasan and Reeves (2005b).

Learner and consumer involvement

Both learners and consumers need to be seen as the focus of interprofessional education for collaborative patient-centred practice (D'Amour and Oandasan, 2005). Learners are the centre of the interprofessional educational process, while the consumer is "at the centre of collaborative care since they are the very reason behind the interdependency of

the professionals" (D'Amour and Oandasan, 2005, p.15). One example of the involvement of consumers in the planning, implementation and evaluation of an educational program is the "Lived Experience of Disabilities" course at Queens University. Consumers participate on an advisory board for the course, in addition to acting as tutors for students, and are involved in the evaluation process.

A number of strategies can be followed to ensure the participation of learners, consumers, families and caregivers, consumer representatives, and health advocacy agencies, in all stages of interprofessional education development and implementation. For example:

- Ensure that interprofessional education activities are developed with patientcentred values as a foundation.
- Involve learners as members of planning or organizing committees.
 This enables their interests, needs, concerns and issues to be represented

patient-centred values and perspectives.

concerns and issues to be represented during development, implementation and evaluation phases.

evaluation phases. Involve consumers, families and caregivers (or appropriate representatives) as members of planning or organizing committees. Their involvement helps to ensure that the planning and development of interprofessional education activities addresses

- Design panel discussions and guest speaker methods to include consumers, families and caregivers as educators in the curriculum.
- Develop and distribute educational materials and sessions, and/or develop centres that are available to educate consumers, families and caregivers about conditions and diseases so that they can make knowledgeable choices about their involvement in collaborative activities, treatment options and self-care (Pautler and Gagné, 2005).

"The course allows students to form a learning relationship with a consumer in which they observe first hand, a person living life with a disability – the challenges and successes. [The students] learn from the expert – the person who lives each and every day with a disability, and can use that perspective as a lens when learning about theoretical concepts."

-Graduate Course Coordinator

Existing Program

The "Lived Experience of Disability" course for occupational therapy students at Queens University (Kingston, Ontario, Canada) is a unique example where consumers, families and caregivers are involved in the development and implementation of a university education program.

Students in the course are paired with a volunteer from the Kingston community who lives with a disability. The course is six weeks in length (36 hours).

Key principles for program design

Curriculum goals

The primary goal of interprofessional education should be to enhance the knowledge, skills/abilities and attitudes of learners to become collaborative partners who work together in an effective collaborative fashion – ultimately, for the benefit of the consumer. Harden (1998) suggests that the main focus of interprofessional education therefore must be on interprofessional knowledge, skills/abilities and attitudes. Interprofessional education planners should not confuse teaching clinical content with the primary goals of collaborative practice. In essence, health professional students may be brought together to study about collaborative mental health practice. However, unless they are learning "how to work together" in the management of mental health issues, they will be learning in parallel—which is "multi-professional" and not "interprofessional" learning. When students use a topic like "collaborative mental health practice" as a focus to learn how to work together, they are engaged in interprofessional learning (Oandasan and Reeves, 2005a).

Principles

The following principles should be considered in the design of interprofessional education curriculum:

- 1. *Goal-directedness*: the interprofessional learning team must have a central purpose or mission to provide a rationale for its existence.
- 2. *Discipline articulation*: the way team members articulate their own role is central to how others come to understand their roles.
- 3. *Communication*: effective communication among team members produces an understanding of the nature of one's own discipline as well as that of others (Clark, 1991).
- 4. *Conflict resolution*: programs should develop the communication skills/abilities, capabilities and readiness of students/learners to handle conflict situations that arise

in the course of teamwork (Parsell et al., 1998; WHO, 1988).

- 5. Relevant learning experiences: the problems/tasks should require or benefit from team action and be capable of being solved or greatly reduced through teamwork (WHO, 1988). A substantial component of the learning should be based in clinical practice (Reeves and Freeth, 2002).
- 6. *Evaluation*: it is important that interprofessional education experiences are evaluated in a way that

Existing program

At the Sharbot Lake Medical Centre (Kingston, Ontario, Canada), family medicine residents are incorporated into the collaborative mental health care team.

This team includes the following professionals: addictions worker, child and family worker, community mental health worker, developmental disability counsellor, family physician, geriatric case manager, mobile community mental health worker, nurse practitioner, psychiatrist, social worker and women's counsellor.

- demonstrates the value of the learning (Oandasan and Reeves, 2005b).
- 7. *Learning strategies*: learning methods that facilitate interaction between health professionals and/or students/learners from different professions are important (Barr, 2002). An appropriate balance of learners from different professions is important in order to promote good interprofessional interaction (Oandasan and Reeves, 2005a).
- 8. *Instructor development*: Barr (1996, p. 244) suggests that "the interprofessional facilitator needs to be attuned to the dynamics of interprofessional learning, skilled in optimizing learning opportunities, valuing the distinctive experience and expertise of each of the participating professions."
- 9. *Timing*: in order to achieve the "best effect," formal interprofessional education should be introduced early in basic or undergraduate curriculum, continued throughout that curriculum, and then reinforced through post-graduate/continuing education. The use of interprofessional education throughout a curriculum ensures:
 - continuity;
 - gradual progression from simple to more complex problems and skills;
 - acquisition of the habit of using an interdisciplinary approach; and,
 - better appreciation of the value of interprofessional education and interdisciplinary teamwork.

Unit 3: Collaborative mental health care teams

Key messages: Unit 3

- An interprofessional team approach allows providers to contribute from their individual areas of expertise and creates an environment for innovative care.
- There are unique benefits of interprofessional team care for consumers, providers, educators and students, and for the health delivery system.
- → The individuals involved on the collaborative team will depend on the needs and wishes of the consumer.
- Team member roles are dynamic.
- Care plan development requires a holistic approach (considering the spectrum of health promotion, illness prevention, treatment, recovery, etc.)

Teamwork in service delivery

Drinka (1996) describes an interprofessional health care team as a group of health professionals from different professions who engage in planned, interdependent collaboration. Within the context of collaborative mental health care, the range of professionals

Note: Collaboration between mental health and primary care services. A CCMHI planning and implementation toolkit for health care providers and planners is a guide for providers wishing to establish or enhance the mental health services they provide through collaboration. Please refer to this toolkit (available at www.ccmhi.ca) for a comprehensive discussion on teamwork.

might include: dietitians, family physicians, mental health nurses, occupational therapists, registered nurses, registered psychiatric nurses, social workers, pharmacists, psychiatrists, and psychologists. Consumers, families and caregivers are also considered integral members of the collaborative team and should be involved in the planning, development, implementation and evaluation of interprofessional education programs and collaborative mental health care activities.

Interprofessional approaches to consumer care are believed to have the potential for improving professional relationships, increasing efficiency and coordination, and ultimately enhancing consumer and health outcomes (Wee et al., 2001; Reeves and Freeth, 2002; Cullen, Fraser and Symonds, 2003). The care provided to consumers by



Implementation

Refer to Section B, Activity 2: "Appreciating Team Member Roles" an interprofessional team is enhanced by the integration of ideas and varying expertise about consumer needs and intervention strategies that would not be possible without the collective insight of the team. Craven and Bland, (2006) provide a summary of best practices for collaborative mental health care, and define low, medium and high levels of collaboration in this context (see Table 3).

Table 3: Levels of collaboration

Levels of Collaboration	High	Moderate	Moderate	Low	Low	Low
Co-location of services	XX	Х	X	X		
Consultation with formal feedback to the primary care provider	XX	X	X	Х		
On-going relationship	XX				X	
Opportunities for case discussion and review	XXX	X				
Shared assessment, decision-making or treatment planning	XXX					
Delegated clinical activities involving feedback of patient information to the primary care provider			X			
Designated clinical activities which do not involve feedback to the primary care proivider						Х

Note: adapted from Craven and Bland (2006).

Effective interprofessional health care teams may be characterized by the following:

- members provide care to a common group of consumers;
- members develop common goals for consumer outcomes and work toward those goals;
- appropriate roles and functions are assigned to each member, and each member understands the roles of the other members;
- the team possesses a mechanism for sharing information; and,
- the team possesses a mechanism to oversee the carrying out of plans, to assess outcomes, and to make adjustments based on the results of those outcomes.

Key principles of effective interprofessional health care teamwork include the following (Grant et al., 1995):

- the focus of team members should be on needs of the patient rather than on individual contributions of team members;
- an important aspect of primary health care is communication with patients (a central principle shared by all health professionals);
- collaboration requires depending on others and contributing one's own ideas toward solving a common problem;
- team members must respect, understand roles, and recognize contributions of other team members;
- teams work both within and between organizations; and,
- individuals have realistic expectations of other team members, which can help avoid role ambiguity, role conflict, and role overload.

Advantages of interprofessional team care benefit consumers, providers, educators and students, and the health delivery system (Grant et. al., 1995):

Consumers

- improves care by increasing the coordination of services;
- integrates health care for a wide range of health needs;
- empowers consumers as active partners in care;
- can be oriented to serving consumers of diverse cultural backgrounds; and,
- uses time more efficiently.

Providers

- increases professional satisfaction due to clearer, more consistent goals of care;
- facilitates a shift in emphasis from acute, episodic care to long-term preventive care and chronic illness management;
- enables the provider to learn new skills and approaches to care;
- provides an environment for innovation; and,
- allows providers to focus on individual areas of expertise.

Educators and students

- offers multiple health care paradigms to study;
- fosters appreciation and understanding of other disciplines;
- models strategies for future practice;
- promotes student participation; and,
- challenges norms and values of each discipline.

Health delivery system

- increases the potential for a more efficient delivery of care;
- maximizes resources and facilities; and,
- decreases burden on acute care facilities as a result of increased prevention and consumer education interventions.

Team member roles

A team-based approach to mental health service delivery is designed to ensure that consumers receive coordinated, quality care. At the primary health care level, collaborative mental health care approaches may involve many people, depending on the needs and wishes of the consumer. It should be clearly noted that team member roles are dynamic and should be considered within the context of the situation. The majority of the following role descriptions were adapted from the CCMHI toolkit, *Working together towards recovery: Consumers, families, caregivers and providers* (available at www.ccmhi.ca).

The person with the mental illness (consumer)

http://www.camimh.ca http://www.cmha.ca

People with mental illness are not always happy with being called a "patient" or "client" because these terms do not acknowledge the importance of their role in their own recovery. "Consumer" is intended to highlight a more empowered role in the treatment partnership.¹

The person with the mental illness is the central player on the team and should play a key role in treatment, recovery and decision-



The CCMHI has developed a toolkit for consumers, families and caregivers. It contains valuable information and resources to support the involvement of these individuals on collaborative teams. It is available at www.ccmhi.ca

making. The consumer has an important role to play in information seeking and being informed, seeking resources and supports in the community, being attentive, honest and expressing feelings, and collaborating with health providers to ensure that quality care is received.

The family member, friend and caregiver

http://www.amiquebec.org

http://www.schizophrenia.ca

Families may be relatives in the way most people think of families. However, family may also include close friends, a same-sex partner or a whole community. A caregiver is anyone who cares enough about the consumer to involve him/herself positively in the care of the consumer. Special note: not all families are helpful and supportive. Some have been abusive and rejecting.

Those who are most unhappy with formal treatment call themselves psychiatric survivors

Self-help and support groups

http://www.mooddisorderscanada.ca http://www.dbsalliance.org http://www.selfhelpconnection.ca http://www.thedreamteam.ca

http://www.nnmh.ca http://www.cmha.ca

http://www.selfhelpnetwork.org http://www.ourvoice-notrevoix.com http://www.heretohelp.bc.ca http://www.schizophrenia.ca

http://www.selfhelp.on.ca

Self-help is people helping people. Its primary benefit is connection—it helps consumers understand that they are not alone. Peer support is self-help but it includes one-to-one help where people who have "been there" help others who are newly diagnosed, in crisis or just discharged from hospital. Peers provide everyday practical advice because they have been through similar experiences. Peer support workers can be volunteers, but more and more they are being hired as paid para-professionals attached to mental health services or self-help organizations. In this more formal role, they may provide counselling, advice on resources, and referrals to services that will be helpful to consumers.

Some self-help and peer support groups are advocates, reaching out to politicians and government policy workers on issues that affect their members' quality of life. They may also speak at schools and community groups or hold information and resource fairs to help educate the general public on mental health and mental illness.

Community mental health professionals

Assertive community treatment teams (ACT Teams)

The members of ACT Teams are psychiatrists, nurses and social workers. If a consumer has a severe mental illness, he or she may be referred to an ACT Team so that he or she can live comfortably and safely outside of the hospital and as independently as possible. ACT Teams help monitor consumers' medication, refer them to other services and stay closely in touch with them through regular visits for as long as they, the team and the consumers' family agree that you need them.

Case managers

Case managers will also work with consumers on a long-term basis. Some provide counselling. Others will help consumers find housing and community support services – and coordinate these services so everyone is working as a team. They will help consumers stay out of hospitals by working with them to prevent a recurrence of their illness. Consumers will likely see their case manager weekly – and they will often be able to visit consumers in their home rather than consumers having to go to their case manager's office. Case managers also work in mental health law courts and help people get treatment if the charges are minor and directly related to mental illness.

Crisis workers

Not all communities have crisis services but for those that do, crisis workers (not always but most often) work with a mobile team that will go to consumers' homes in an emergency. Sometimes, the police may be the first people to arrive but, if the crisis is related to the consumer's mental illness, they will call a crisis worker (or one will come with them) who is specially trained to help. Some communities have crisis programs that consumers or their family can call directly. This approach is less upsetting than having the police in a consumer's home. The crisis worker stays with the consumer until he or she feels better and then follows-up in the next several days or weeks to see that the consumer is referred to services so he or she can avoid a crisis in the future.

Housing workers

If a consumer lives in supportive housing, there may be staff working there to help him or her settle in and get to know his or her neighbours. Housing workers often organize tenants' meetings, social events or work-parties to do common chores (if the tenants are required to help out). Some housing situations have staff 24 hours a day, 7 days a week. In other cases, the staff are available on call or at specified hours.

Peer support workers

People who have had a mental illness or who are a family member may volunteer to help others, or they may be paid para-professionals. They work in consumer or family organizations or in professionally managed mental health services. They may be called by different titles such as Peer Advocate, Peer Counselor or Peer Outreach Worker but they all have one thing in common – they have "been there."

Vocational counsellors

Some programs help consumers to finish their education and/or to develop the skills to work. Then, they support consumers through the process of finding and keeping a job. Vocational counsellors also work with employers to find jobs for people and ensure that they are educated about mental illness.

Some other names for professionals who perform these roles, as described above, are National Native Alcohol and Drug Abuse Prevention Worker (NNADAP Worker), mental health therapist, wellness worker, community and social development worker, addiction worker or alternative worker – the main thing is for to ask what they do, not what they are called.

Other professionals who can help you

Art and music therapists

Some people find that their recovery is aided by creative expression. Art therapy allows people to deal with overwhelming emotions in ways other than talking about them. They also help people find their creative side and relate it to their psychological and mental

well being. Some sponsor art shows where work is exhibited and sold. Music therapists know that the heart is touched by music. Creating or listening to music is healing.

Psychotherapists

Psychotherapists may have many professional backgrounds. Psychotherapy is not a registered health profession (there is no formal regulatory body) so consumers need to be sure that the person they are seeing has proper training. Psychotherapists work from a wide variety of approaches. Note that only family physicians or psychiatrists have their fees paid by Medicare – other psychotherapists will charge fees (unless they work for a hospital or community agency). Visit http://www.aboutpsychotherapy.com/, a British site that offers information on the models of psychotherapy and what they can do for you.

For people who are working

Employee assistance programs (EAPs)

Many workplaces now offer employees, as part of their health benefits package, confidential counselling for emotional, marital, mental health and addiction problems. While sessions are limited (approximately six per employee), EAP counsellors can provide referrals to community services and longer term counselling. Some EAPs offer workplace training on subjects such as wellness, recognizing the signs of mental illness and accommodation.

Registered health professionals

The dietitian

http://www.dietitians.ca

Nutrition plays a key role in mental health, including recovery from substance abuse, in mood and eating disorders, and in combating the side effects of certain psychiatric medications. Weight management, diabetes, blood levels affecting heart disease, high blood pressure, heartburn/reflux, food allergies, swallowing problems and access to good food are just a few of the issues dietitians can address. Dietitians may be available through outpatient clinics, homecare centres and through mental health programs. The Dietitians of Canada has a consumer-friendly web site http://www.dietitians.ca/ (bilingual) that has resources for healthy eating and instructions on how to find a nutrition professional. The Consulting Dietitians Network's toll free line (1-888-901-7776) is also available to provide referral to dietitians in private practice. In British Columbia there is a Dial-A-Dietitian line (1-800-667-3438) that provides answers to nutrition-related questions.

The family physician

http://www.cfpc.ca

The family doctor is a personal physician and health advocate from birth to old age. In addition to having a medical degree, the family physician receives additional training in the diagnosis and treatment of a wide range of health problems, and learns to provide care in different settings (hospital, clinic, home) with other health care providers. This

expertise enables family doctors to see patients through the little problems as well as the bigger health problems that relate to both physical and emotional health. Family doctors can also work with patients to minimize risk of becoming ill and advise on the best ways to stay healthy. A family doctor is part of a network of health care professionals in helping patients/consumers access the care they need.

The occupational therapist

http://www.caot.ca

Occupational therapists help consumers identify the daily activities in their life that are important to them - but may be causing them difficulty. They work closely with consumers to develop ways of overcoming these difficulties. They address a broad range of activities such as self-care and community living, to education, work, parenting, recreation and leisure. They evaluate why problems are occurring and suggest approaches to compensate for these difficulties. Some problems consumers might have include trouble with concentration or memory, difficulties getting organized, a hard time making plans to return to work or difficulty negotiating workplace accommodations with a consumer's employer. Another thing an occupational therapist might do is develop (with the consumer) an activity schedule that promotes success in tackling the day-to-day challenges but which also supports a consumer's mental health and well-being.

The pharmacist

http://www.pharmacists.ca

Pharmacists fulfill several roles for the consumer, including clinician, educator, information resource, and purveyor of medications. As clinicians, pharmacists work to ensure that the consumer is taking the right drug at the right dose for the right reason and is not taking any unnecessary medications. They provide guidance on how to start, maintain, combine, switch, and stop medications and monitor for treatment related benefits and adverse effects. Pharmacists provide education to consumers and to other members of the collaborative health care team about medication related issues, either one-on-one or in more formal group education settings.

As very accessible health professionals, pharmacists are well suited to answer questions from consumers and their caregivers as well as from their collaborative colleagues. This is a particularly critical role considering the complex nature of the pharmacologic treatment of mental illnesses. The most well known role of the pharmacist is the dispensing role. It is important that consumers ensure that their pharmacists are aware of all of their medications to ensure the desired outcomes are achieved and adverse effects such as drug interactions are avoided. This is best achieved when consumers procure all prescription and other medications from the same pharmacy.

The psychiatrist

http://www.cpa-apc.org

A family doctor may refer a consumer to a psychiatrist to help with diagnosis and finding the right medication. The psychiatrist may involve family members or caregivers at the request of the consumer and recommend the consumer's treatment plan. Psychiatrists also provide consultations to family physicians and to community mental health services. In the case of consultation, the consumer may not actually see the psychiatrist, but the psychiatrist will be working on behalf of the consumer.

The psychologist

http://www.cpa.ca/Psychologist/psychologist.htm

Psychologists assess and diagnose psychological problems, sometimes with the use of psychological tests. They may also offer psychotherapy, which can help consumers understand why they think, feel and behave the way they do, and they can help consumers in distress figure out what they can do to make changes in their lives. Some psychologists work for hospitals, clinics, jails or school boards where their services are covered by public health insurance. Others work in private practice where they charge a fee for their services. If the consumer is employed and has a health benefits plan, it may offer from \$500 to \$1000 per year for the services of a registered psychologist.

The registered nurse

http://www.cna-nurses.ca/cna/

Registered nurses work in many locations throughout the entire health care system. They will help consumers with all of their health needs—some of which will relate to mental illness. Nurses can provide counselling, help consumers monitor their medication, make referrals and advocate for consumers, and provide teaching about healthy living. Some nurses work in community roles such as case managers or crisis workers. Others have advanced training and are called nurse practitioners. Working in consultation with a physician, these nurses offer a broader range of health services, including diagnosis and the prescription of some medications—things that only doctors used to be able to do.

The registered psychiatric nurse

http://www.cfmhn.org

http://www.psychiatricnurse.ca

Registered Psychiatric Nurses provide health care to persons in a variety of settings. Their focus is on the mental and developmental health of persons within the context of their overall health and life situation. Their education provides a special focus on mental health and mental illnesses. Their knowledge and skills include needs assessment, program planning and therapeutic interventions. They practice where people live, work and play as well as in hospitals and community clinics/services. They are often the only mental health resource available to a rural or remote community and therefore work closely with other members of the community to meet the diverse mental health needs of its people.

These are nurses specially trained to help people with mental illness. They work in mental health services, both in hospitals and in the community. They can provide you, your family or caregiver with education, advice and counselling – and they are skilled at helping you monitor your medication.

The social worker

http://www.casw-acts.ca

Social workers help with personal problems in the context of consumers' relationships, family, community and life circumstances (e.g., poverty, childhood trauma, domestic violence, marginalization, culture heritage and many other situations that are unique to consumers). Some social workers provide counselling or psychotherapy. Many work in positions where their job is to get to know the services in the consumer's community and, with the input of the consumer, refer the consumer to the ones that will help him/her live independently. Their roles in mental health agencies or hospitals include health teaching, and treatment and rehabilitation services. They will work with individuals, couples, families and/or community groups.

Interprofessional care planning

An interprofessional team developing care plans for consumers must be able to approach care holistically, consider the needs of the consumer, and identify and integrate important pieces of information (Hyer et al., 2003). The ability of each discipline to contribute to the care plan



Implementation

Refer to Section B, Activity 1: "Steps in Assessing Patient/Client Needs"

will depend on each team member's understanding of the consumer's needs, problems and goals. The team may agree that "optimal health" is the goal for the consumer. However, the means for achieving or arriving at the goal may differ between professions. These differences are in part a result of each discipline's background training, expertise and approaches to problem solving and consumer care. These differences are a significant element of interprofessional collaboration, as unique perspectives enable team members to view and approach problems in new ways. The various viewpoints and expertise must be embraced and respected by the team, and integrated as part of the interprofessional approach to consumer care.

Keeping records

An interprofessional care plan, whether it is developed for an individual consumer or a community, will not work unless the team has a system for recording and monitoring who will be responsible for what and by when. This record keeping should be completed before the end of team meetings and be available to all team members to remind them of their tasks/responsibilities. In addition, the team must have in place a system (formal and informal) for communicating on the steps of the plan between team meetings. Some

communication may be informal with different professions talking with each other as needed.

Care models

There are three effective care models readily employed in mental health care. These models should be emphasized in interprofessional education in the context of collaborative mental health care, and be considered when designing an interprofessional care plan.

Holistic care

In a holistic, goal-oriented model, health is defined not as an outcome, but as a process. Through this process, health care professionals must enter into a dialogue with the consumer. As a result of this dialogue, a collaborative relationship develops in which a broader array of health professionals is invited to share in the personal health goals attainment of the individual. This holistic model of care has also been referred to as "patient-focused care" and has been described as the extent to which clinical care is coordinated across the continuum of sites and services.

A holistic, goal-oriented model embodies fundamentally the following assumptions (Clark, 1995):

- health must ultimately be defined by each individual, and it may be different for different persons and for the same person at different times;
- an individual's health goals can best be determined through a dialogue involving the individual and his or her health care provider(s), each using the special information they bring to the caring relationship;
- the development of health goals requires assessing the individual's strengths and resources, interest and needs and personal values, in addition to determining obstacles and challenges;
- final decisions about health goal priorities, and the amount of effort expended in their achievement, must reside with the individual—health professionals must decide whether their involvement will be beneficial and how they can participate; and,
- success for both the individual and the health professional is measured by the extent to which the individual's health goals are achieved.

Recovery paradigm

Another model that could be considered in the provision of collaborative patient-centred care is the recovery paradigm (Pautler and Gagné, 2005). Principles of recovery, when applied to the community mental health system, require shifts in provider attitudes and practices (Trainor et al., 2004). The consumer is viewed as an active participant within a supportive community. The goal of recovery is primarily one of self-actualization. Clinical treatment and other sources of support are only parts of the systems and structures that assist consumers with their recovery; consumers' participation and

membership in the community are the result of self-help and the implementation of other services such as supported employment and peer support (Pautler and Gagné, 2005).

Anthony (2000) and Jacobson and Greenley (2001) highlight key principles of the recovery paradigm and define recovery as:

- a concept grounded in the fundamental belief that people can and do recover from mental illness, and are able to get on with living meaningful lives, despite their mental illness;
- a process, a state of being and becoming—something that is worked on or emerges over time;
- something defined by the individual person working toward it, something that is highly personal and unique;
- something achieved through many different paths supported by clinical and other services; and,
- an active, rather than a passive process that respects all rights of a person's full citizenship (as presented in Pautler and Gagné, 2005).

Chronic care model (Chronic disease management model)

Chronic disease management involves productive interactions between informed and empowered consumers (and their families) and a prepared and proactive practice team. The core principles of this model include: consumer-centredness, a focus on self-management and education, and interdisciplinary collaboration. One particular framework that is used in primary health care to enhance outcomes is the chronic care model. This model contains both macro- and micro-elements and has been applied to case studies such as depression care (Schaefer and Davis, 2004).

Core competencies (and examples) for caring for consumers with chronic conditions include (WHO, 2005):

- *Patient-centred care* supporting self-management, assisting changes in health-related behaviours, and interviewing and communicating effectively.
- Partnering with consumers, other providers and communities.
- Quality improvement measuring care delivery and outcomes, managing change effectively, identifying and implementing best practices.
- *Information and communication technology* designing and using patient/client registries, and using technologies to enhance communication.
- *Public health perspective* providing population-based care, systems thinking, providing care across a continuum, working in primary health care-led systems.

Section B: Implementation

Notes to the facilitator

Preparing yourself

In order to effectively facilitate this workshop, it is important that you have a thorough knowledge of the materials contained in Sections A and B of this toolkit. Depending on your comfort level with the principles, concepts, activities



Not sure if interprofessional education is right for you or your organization? See *Appendix B: Decision Guide*.

and case studies provided, you may wish to read additional material on interprofessional education and collaborative mental health care to enhance your knowledge of these two areas.

Prior to implementing a workshop, it is important to consider that participants may be at different stages of readiness to engage in collaborative efforts. The goals and needs identified by groups or individuals who are just learning to collaborate may vary from those who have been involved in collaborative education, and/or who have been collaborating for a longer period of time. Therefore, the workshop and the activities you implement may vary depending on the group.

In addition, opportunities to include consumers, families and caregivers, and other individuals who do not necessarily hold professional designations (e.g., representatives from community agencies, peer support workers, community mental health workers, etc.), should be explored and encouraged when designing, implementing and evaluating interprofessional workshops.

Your role as the facilitator

Although this educational workshop is set within the context of collaborative mental health care, it is essential to remember the importance of discussing process issues related to interprofessional education and working in an interprofessional team environment. This means that it is your role to ensure that concepts and principles around processes—such as trust, respect, role clarification, and perceptions—are adequately addressed. Discussions involving these issues can be challenging, as participants work to expand their understanding and appreciation of the roles, skills and expertise of other team members. Part of your role is to guide the activities and discussions within the workshop so that conflicts are managed constructively. At the end of the workshop, all participants should achieve a deeper understanding of how they and their consumers can benefit from working collaboratively.

Participants may come from a variety of backgrounds. It is important that all participants feel that they can contribute to the workshop activities, and it is your responsibility to ensure that everyone's roles, skills and expertise are respected and appreciated.

Selecting and preparing participants

If possible, try to obtain some basic details about the participants before the workshop. The information they provide about who they are as individuals and their experience working/learning in the areas of interprofessional education and/or collaborative mental health care may assist you in tailoring the program to better meet their needs. Knowing as much as you can about the participants and their goals will help you choose the most appropriate activities for the workshop.

Encourage participants to prepare in advance for the workshop by reading and reviewing all or parts of the information contained in Section A and/or B of this toolkit. This may save the group time when reviewing background concepts and principles, and may allow the group more time to focus on the interactive activities and case studies.

Organizing the workshop

- 1. Take time to structure the outline of your program and practice the materials in advance of the workshop. As a guide, a sample lesson plan is provided in this section of the toolkit.
- 2. It is important that the participants in your workshop feel engaged in the program materials and that they enjoy the process. Ask participants to articulate their goals for the workshop and attempt to meet these goals as a group.
- 3. Be considerate of the participants' needs and the resources they are investing into this program (e.g., time, energy, money or other). Consider the following suggestions:
 - Start and end on time—ask permission from all of the participants to run late.
 - Have regular breaks and provide or allow nutritional refreshments.
 - Appeal to a range of learning styles (e.g., visual, kinaesthetic and auditory).
- 4. Set a standard (expectations) for participation and group behaviour before the workshop begins. Consider the following:
 - What are your expectations around using non-bias, non-racial and inclusive language? What personal biases might you hold,

Expectations for Participants:

- 1. Respect
- 2. Trust
- 3. Participation
- 4. Language
- 5. Communication

and how might you manage these during the discussions?

- What happens if a participant chooses not to join in a particular conversation because he/she feels uncomfortable? What steps could you take to encourage that person's continued involvement in the workshop?
- What happens when conflict arises between workshop participants, or between you and a workshop participant? How will you approach this situation?
- 5. It is essential that you leave time to debrief the participants at the end of the workshop. This is an opportunity for participants to share what they have learned and to raise additional questions or concerns. Depending on the group, it is also a time for participants to reflect on how they will incorporate their learning into their daily/clinical activities (e.g., "next steps").



Sample lesson plan

FULL-DAY WORKSHOP (9:	.00 am - 4:30 pm)
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Washahan Osmanan	Fating start Times Demoined
Workshop Component	Estimated Time Required
Introductions and expectations for participants	20 minutes
Section A: Background	
Units 1, 2 and 3	20 minutes
Section B: Implementation	
Activity 1	60 minutes
Break 1	15 minutes
Activity 2	60 minutes
Break 2 (lunch)	60 minutes
Case Study*	90 minutes
Break 3	15 minutes
Case Study continued	60 minutes
Debrief/closing remarks	40 minutes
Evaluation	10 minutes

^(*) Note: There are four case studies to select from. Depending on the size of the group, you may decide to split the participants into smaller groups and have the groups complete different case studies.

Suggested modifications for a half-day workshop:

- 1. Have participants review the materials in Section A prior to the workshop, and limit time on this section to questions of clarification. Assume that participants are comfortable with this background information.
- 2. Spend the majority of the workshop on a combination of fewer activities and case studies. Or you may reduce the time spent on each activity. Select the activities/case studies that are most relevant to the needs and goals of your participants. You may want to identify this information for your participants before the workshop.
- 3. Have at least one break of 15 minutes.
- 4. Condense the time allotted for debriefing.
- 5. Have participants complete the workshop evaluation.

Summary of materials:

Activity 1: Steps in assessing patient/client needs

- Participant instructions
- Activity 1: Handout

Activity 2: Appreciating team member roles

- Participant Instructions
- Activity 2: Handout

Case studies

- Case study overview handout
- Team member role reflection worksheet
- Attitude reflection worksheet
- Case study 1
- Case study 2
- Case study 3
- Case study 4

Workshop evaluation

Evaluation handout

Activity 1: Steps in assessing patient/client needs

Teams are generally organized to achieve specific programmatic goals. Primary health and mental health care providers will work with consumers, families, caregivers, communities, stakeholders



This activity relates to the information presented in *Section A: Unit 3*

and others to achieve patient/client and/or population health goals. In order for an interprofessional team to function effectively, the team's purpose and goals should be clearly understood and agreed upon by all members.

Once the team, patient/client and family have discussed and identified goals, team members, including the patient/client, will need to identify what this may mean in reality. The process of interprofessional team care planning is the means of achieving consensus on desired patient/client and/or population health outcomes; it encompasses the goals of the patient/client as the fundamental purpose for collaboration. The following activity was adapted from Hyer et al., (2003).

Notes to the facilitator:

- This activity may be completed as one group or in a series of smaller groups (4–6 participants), depending on the size of the workshop.
- 2. If you decide to use one or more of the case studies provided in this toolkit for this activity, you might consider removing the text boxes that provide discussion information to decrease confusion. Or simply ask participants to disregard the text boxes for the purpose of this activity.

Facilitator instructions

Handling a complex case requires team members to consider the patient/client's medical, emotional, social, environmental, spiritual and economic needs.

Activity 1: Objectives

Upon completion, participants will be able to:

- describe and value the roles of other health professions in the management of patient and/or population health issues;
- formulate an interprofessional care plan with other health care professionals which addresses patient health and/or population health goals.

Time: 60-90 minutes

Materials:

- Participant instructions handout
- Activity 1: Handout
- Case study (there are four to select from)
- 1. Select a complex and comprehensive case study in which there is a variety of issues to be addressed and in which different providers have a role to play in addressing these issues.
- 2. Provide the participants with copies of the appropriate case study and the participant handout.

- 3. Have the participants read through the case study independently.
- 4. Instruct the participants as a group to use the grid and the questions provided to complete the activity handout. Have them consider the holistic (bio-psycho-social) needs and situation of the patient/client.
- 5. Instruct the participants to identify the expected activities and the responsibilities of each team member (e.g., initiation, follow-up, and reporting results).
- 6. Allow approximately 45 minutes for these tasks

Once the group(s) has completed the handout, generate a large group discussion with the participants and debrief their experience. Consider the following questions:

- 1. Does anyone have any overall comments or observations following this activity?
- 2. What did you learn about the roles of different professions? Can you identify any areas of overlap?
- 3. Is there a difference between your usual care planning and this activity?
- 4. Allow approximately 15 minutes for discussion.

Participant instructions

Please read the case study provided. Considering the patient/client's medical, emotional, social, environmental, spiritual and economic needs, answer each of the following questions as a group:

- 1. What is the overarching goal? At least three perspectives need to be considered and reconciled: patient/client, his/her family, and the team.
- 2. What are the patient/client's problems? (e.g., medical, emotional, social, spiritual, environmental, economic, or other).
- 3. What is the impact of each problem on the patient/client's health?
- 4. What strengths and resources does the patient/client have or can be mobilized to deal with each problem?
- 5. What additional information is needed to adequately define the problem or its implications?
- 6. What is the plan of care? (What needs to be done; who will do it; when will it happen?)
- 7. What priority should be assigned to each problem? How important is its effect on the overarching problem?
- 8. What outcomes should be expected for each problem? (e.g., expressed in measurable terms, appropriate time to look for the outcomes)

Once all of the information on the handout is completed, wait for further instructions from the workshop facilitator.

Activity 1: Handout for Participants

Interprofessional Care Plan Matrix*

Overarching Goals:	
Patient/client:	
Family:	
Team:	

Problem	Impact on Health and Quality of Life	Strengths/ Resources	Plan (what, who, when—includes getting more information)	Expected Outcome (what to look for and when)
1.				
2.				
3.				
4.				
5.				
6.				

^{*}This handout was adapted from Hyer et al. (2003).



Activity 2: Appreciating team member roles

An important objective of interprofessional education is to enhance the respect and attitudes that providers have for members of different professions. This goal can be accomplished by:



This activity relates to the information presented in *Section A: Unit 3*

- addressing stereotypes and misconceptions,
- increasing awareness of role differences and similarities, and
- acknowledging the unique contributions of each provider.

For the purposes of this toolkit, team members include professionals and all other team members who do not necessarily hold a professional designation. This includes consumers, families, caregivers, peer support workers, and representatives of community agencies.

Facilitator instructions

Step one: Interprofessional perception scales (Mariano et al., 1999)

Explain that the purpose of the exercise is for the participants to personally reflect upon the perceptions that they have about the roles and responsibilities of other team members who provide mental health services in primary health care settings. Let them know that at the end of the activity, you will generate discussion around how their perceptions may have changed, and what contributed to the shift in thinking.

Activity 2: Objectives

Upon completion, participants will be able to:

 describe and appreciate the expertise and roles of different health care professionals and other team members who provide mental health services in primary health care.

Time: 60-90 minutes

Materials:

- Black and red markers
- Flipchart(s)
- Tape
- Participant instructions
- Activity 2: Handout for participants
- 1. Ask the participants to complete the "Interprofessional Perception Scales" handout, specifically noting the various professions/team members represented on their own collaborative mental health care team or in the workshop.
- 2. Tell the participants that their ratings will be kept private (i.e., they do not have to share their responses with other participants).
- 3. Inform the participants that you will return to these assessments at the end of this session.
- 4. This should take about 10 minutes.

Step two: Talking wall exercise (Parsell et al., 1998)

Phase I:

Introduce the "Talking Wall" exercise. The activity is intended to allow participants to explore their conceptions and misconceptions of the roles and responsibilities of other health care professionals/team members who provide mental health services in primary health care.

- 1. Organize participants into subgroups of 4-6 people.
 - a. Tell each subgroup to attach a flipchart sheet to the wall for each profession/team member represented in the subgroup.
 - b. Using **black** markers, ask the participants to write their perceptions of the roles and responsibilities of the team members on the respective sheets, with the exception of their own. Only new items should be added to the lists to avoid duplication.
- 2. Once the lists are complete, ask the participants to examine their own profession's/team member list.
 - a. Using a red marker, ask the participants to delete misconceptions, correct inaccuracies and add missing items. The use of two colours allows the group to distinguish easily between perceived differences in role perceptions.
- 3. This phase takes about 20 minutes.

Phase II:

This phase of the activity provides a unique opportunity for interprofessional discussion in which group members are encouraged to ask as many questions as possible. It provides participants with an opportunity to demonstrate the breadth and depth of their own professional/team member role.

- 1. Ask each participant to discuss his or her own flipchart list with the rest of the subgroup and clarify the various points that were raised.
- 2. This phase takes about 15 minutes.

Phase III:

In a plenary, facilitate a large-group discussion with all of the participants.

- 1. Ask the participants to reflect on this experience and share any new learning and personal benefits.
- 2. Ask a volunteer to share his or her comments, and continue with the other participants sharing in a clockwise manner until everyone has had an opportunity to speak. Participants can "pass" if they have nothing new to add to observations already made.
- 3. This phase takes about 15 minutes.

Step three: Interprofessional perception scales (continued)

Have the participants review the "Interprofessional Perception Scales" they had completed previously.

- 1. Ask them to consider their initial responses in light of the "Talking Wall" exercise.
 - a. What changes would they like to make?
 - b. What areas of overlap in patient/client care skills, roles or expertise exist between professionals/team members?
- 2. Lead a group discussion on the possible reasons for certain perceptions or misconceptions of certain health care professions/team members.
 - a. Why do certain stereotypes or misconceptions of other professions/team members exist?
 - b. Did you gain a greater understanding and appreciation for the roles of other team members?
 - c. How do perspectives and understanding of other health care professions/team members influence teamwork?
- 3. This should take about 15 minutes.

Participant instructions

Interprofessional perception scales (Mariano et al., 1999)

- 1. Using the "Interprofessional Perception Scales," please reflect upon your perceptions of other health professions/team members and rate these perceptions according to the items and scales indicated.
- You will not have to share your ratings for each profession/team member with
 members of the group. However, it is essential that you consider your honest opinions
 of other team members so that you may reflect on how these perceptions change after
 completing the "Talking Wall" exercise.
- 3. Please consider the different professions/team members represented on your own collaborative mental health care team or those represented in this workshop.
- 4. You have 10 minutes to complete this task.

Talking wall exercise (Parsell et al., 1998)

The "Talking Wall" exercise is intended to allow participants to explore their conceptions and misconceptions of the roles and responsibilities of other health care professions/team members who provide mental health services in primary health care. Participants will be assigned to subgroups of four to six people.

Phase I (20 minutes)

- Each subgroup is to attach a flipchart sheet to the wall for each profession/team member represented in the subgroup. Indicate the name of the profession/team member on each flipchart sheet using a **black** marker.
- 2. Using **black** markers, participants write their perceptions of the roles and responsibilities of each of the professions/ team members on the respective sheets, with the exception of their own.

- 3. Only new items are added to the lists to avoid duplication.
- 4. Once the lists are complete, participants are to examine their own profession's list and, using a **red** marker, delete misconceptions, correct inaccuracies and add missing items.

Phase II (15 minutes)

The participants then discuss their own profession's/team member's flipchart list with the rest of the subgroup participants and clarify the various points that were raised. Other participants are encouraged to ask questions.

Phase III (15 minutes)

Your facilitator will now lead a group discussion.

Interprofessional Perception Scales (Mariano et al., 1999)

- Reflect on your initial comments.
- Are there any changes you would like to make after having completed the activity?
- The workshop facilitator will prompt you with questions and lead a group discussion.

Activity 2: Handout for participants

Interprofessional Perception Scale

What is your opinion/perception of persons in other professions/team member roles? (Fill in "Persons in This Profession" blanks with professions** other than your own.)
Fill in the blanks from 1–4, where 1 is "very untrue" and 4 is "very true."

Item	Persons in This Profession							
(e.g.								
1. Are competent								
2. Have very little autonomy								
3. Understand the capabilities of your profession								
Are highly concerned with the welfare of the patient/client								
Sometimes encroach on your professional territory								
6. Are highly ethical								
7. Expect too much of your profession								
8. Have a higher status than your profession								
Are very defensive about their professional prerogatives								
10. Trust your professional judgement								
11. Seldom ask your professional advice								
12. Fully utilize the capabilities of your profession								
13. Do not cooperate well with your profession								
14. Are well trained								
15. Have good relations with your profession								

Note: This handout was modified from Mariano et al. (1999). **For the purpose of this workshop, participants should read 'profession' as including any team members (who may or may not have a professional designation).



Activity 3: Case studies

It has been suggested that interprofessional education should have a substantial component of learning that is based in clinical practice (Reeves and Freeth, 2002). Cooperative learning strategies, such as case-based or problembased learning, are also effective methods for making a connection between learning and interprofessional teamwork in the practice setting (D'Eon, 2005).

Case study notes for the facilitator

The learning objectives of interprofessional education are incorporated into every case so that learning should not be dependent on the choice of case. You may choose the case(s) you feel appropriate for the participants of the workshop. Learners may help choose cases in keeping with principles of adult education. Cases with features most similar to participant's

Activity 3: Objectives

Upon completion, participants will be able to:

- describe and appreciate the expertise and roles of different health care professionals and other team members who provide mental health services in primary health care:
- describe various challenges and benefits of working in an interprofessional team; and,
- develop strategies for working in an interprofessional team.

Time: 60–150 minutes (1–2.5 hours) per case study

Materials:

- Participant instruction handout
- Copies of both worksheets (Team Member Role Reflection, and Attitude Reflection Worksheets)
- Copy of case study

clinical setting may be more relevant and productive in facilitating genuine team interaction and highlighting interprofessional education learning objectives.

Toolkit case-based learning materials are designed to be contextually and clinically relevant for teams offering mental health services in primary health care settings. Each case attempts to portray fairly common generic clinical scenarios across a variety of settings. The subject matter purposely limits clinical details and specifics to allow for a wide range of interactions and contributions from participants. Participants should not get hung up on missing content, and you should encourage the participants to fill in the case content if they feel it is necessary. This allows participants to educate other team members about discipline-specific content, thereby fostering the learning objectives of interprofessional education.

- Remember that the cases attempt to highlight concepts of interprofessional education as they manifest in real-world clinical settings.
- Participants will likely discuss discipline-specific content in relation to the clinical situation; it is your role to emphasize interprofessional education learning objectives.

- Stay attuned to interactional process of learning sessions, as these are ideal teachable
 moments for interprofessional education (e.g., communication between team
 members, conflict resolution, role clarification, respect, trust, etc.).
- Reflection, discussion, and role-play exercises can facilitate learning. In addition to learning about interprofessional education, it is expected that much of the learning amongst the participants will be transformational and attitudinal in nature.
- You may choose to highlight and reflect on these transformational shifts as they occur for the participants.

Facilitator Instructions

Step one: Worksheets (before the case studies)

The purpose of the worksheet exercise is for the participants to personally reflect upon the perceptions that they have of other team members and why they have them. Let them know that at the end of the activity you will generate discussion around how their perceptions might have changed.

- 1. Have the participants complete both the "Team Member Role Reflection Worksheet" and the "Attitude Reflection Worksheet" prior to reading through the case study.
- 2. Tell the participants that their ratings are kept private (i.e., they do not have to share their responses with other participants, and thus, they do not have to 'fill in' the sheet).
- 3. Ask the participants if there are any team member roles with which they are not familiar. If there is a gap in understanding, ask one of the participants to offer a description of what this team member does. If needed, be prepared to provide a description yourself, or to add to the description provided.

Step two: Case studies

- 1. Divide the participants into small groups of 4–6. You may want to consider the types of professionals/team members, and consumers, families or caregivers that are represented in various groups. When appropriate, consider a role-playing activity where group members have an opportunity to exchange roles with another team member (e.g., a consumer takes the role of a social worker, a family physician takes the role of a consumer, and so on). When role-playing, participants should take on the characters/roles that are expressed within the given case study.
- 2. Have the participants read through the case study once independently.
- 3. Ask the participants to go through the case study as a group, and *facilitate their own group discussion* using the notes provided. You may consider assigning one person to lead the group and/or to keep notes on the conversation.

Step three: Worksheets (after the case studies)

- 1. Ask the participants to review the worksheets they completed before the case studies and re-rate their perceptions. How has their understanding/perceptions shifted or changed regarding the skills and expertise of other team members?
- 2. If they have gained a greater appreciation or understanding of the roles of other team members, how has this affected their level of trust and respect? Can the participants identify benefits to working collaboratively with other team members?
- 3. Ask the participants to consider how they might continue to foster trust, respect and effective communication in their own teams.

Case Study Notes for the Participants

The toolkit case-based learning materials have been designed to be contextually and clinically relevant for teams offering mental health services in primary health care settings. Each case attempts to portray fairly common generic clinical scenarios across a variety of settings. Cases are written from varying perspectives to get you thinking about the perception and contribution of a wide variety of team members. The subject matter purposely limits clinical details and specifics in the hope of allowing a wide range of interaction and contributions from participants. Do not get "caught-up" on missing content, and feel free to fill in the case content if you feel it is necessary.

You are expected to educate—and learn from—other team members about your particular area of expertise and contribution to the care of the patient/client, thereby fostering the learning objectives of interprofessional education. As you work through a case, your group should focus on interprofessional education themes (e.g., roles of team members, communication among the team, conflict resolution, etc.). Reflecting, discussing and even role-playing these team issues may be part of the learning. The exercise should help bring to life many of the learning objectives of interprofessional education as they relate to your care of patients/clients. In addition to gaining knowledge about interprofessional education, it is hoped that you have a chance to reflect on your attitudes and values towards working collaboratively.

Participant Instructions

Worksheets

- 1. Complete both the "Team Member Role Reflection Worksheet" and the "Attitude Reflection Worksheet" prior to reading through the case study (you do not have to 'fill in' the sheet if you choose not to).
- 2. You will not have to share your responses with members of the group. However, it is essential that you consider your honest opinions of other team members so that you may reflect on how these perceptions change after completing the exercise.

Case Studies

- 1. Divide into small groups of 4–6. When appropriate, consider a role-playing activity where group members have an opportunity to exchange roles with another team member (e.g., a consumer takes the role of a social worker, a family physician takes the role of a consumer, and so on). When role-playing, participants should take on the characters/roles that are expressed within the given case study.
- 2. Please read through the case study once independently.
- 3. When instructed, begin to go through the case study as a group, and use the notes provided to facilitate a group discussion. Consider identifying a group leader and/or someone to keep notes on the conversation.

Team member role reflection worksheet

Please rate your perceived level of responsibility for the role items indicated below.

For example, if role responsibility for a particular item is shared between you and another team member(s), you might rate your responsibility near 50.

	Roles	I have little responsibility, other team members have major responsibility	I have major responsibility, oth team members ha little responsibilit	ive
		0%	50% 10	0%
1.	Contacting the patient/client			
2.	Defining the initial clinical needs			
3.	Gathering relevant information			
4.	Analyzing and formulating the information			
5.	Making a diagnosis			
6.	Giving the patient/client feedback			
7.	Making treatment recommendations			
8.	Deciding on team actions			
9.	Planning how to involve others in treatment implementation			

	Roles	I have little responsibility, other team members have major responsibility	I have major responsibility, other team members have little responsibility
		0% 50%	5 100%
10.	Being accountable in event of a poor outcome(e.g., drug reaction, suicide, etc.)		
11.	Providing direct support/care to patient/client		
12.	Working with patient/client's family members		
13.	Helping the patient/client arrange social supports (e.g., housing, finances etc.)		
14.	Being the team leader		
15.	Making a diagnosis		
16.	Giving the patient/client feedback		

Note: this handout was adapted from Thomas Ungar, MD, copyright, 2001. The activity was first presented at the faculty development conference "The Collaborative Mental Health Project, Ontario College of Family Physicians, Toronto, February 17, 2001." This exercise was successfully implemented as a reflection and discussion activity for teams.

Attitude reflection worksheet

Please rate the degree of appreciation you have for the skills and expertise of the following team members (where 0 is no appreciation, and 10 is high appreciation).

Team Member		None Somewhat			High		N/A				
	0									10	
Person with Mental Illness	0	0	0	0	0	0	0	0	0	0	
Family or Friend of the Person with Mental Illness	0	0	0	0	0	0	0	0	0	0	
Caregiver of the Person with Mental Illness	0	0	0	0	0	0	0	0	0	0	
Dietitian	0	0	0	0	0	0	0	0	0	0	
Family Physician	0	0	0	0	0	0	0	0	0	0	
Mental Health Nurse	0	0	0	0	0	0	0	0	0	0	
Nurse (other than a registered nurse or mental health nurse)	0	0	0	0	0	0	0	0	0	0	
Occupational Therapist	0	0	0	0	0	0	0	0	0	0	
Pharmacist	0	0	0	0	0	0	0	0	0	0	
Psychiatrist	0	0	0	0	0	0	0	0	0	0	
Psychologist	0	0	0	0	0	0	0	0	0	0	
Registered Nurse	0	0	0	0	0	0	0	0	0	0	
Registered Psychiatric Nurse	0	0	0	0	0	0	0	0	0	0	
Social Worker	0	0	0	0	0	0	0	0	0	0	
Other:	0	0	0	0	0	0	0	0	0	0	
Other:	0	0	0	0	0	0	0	0	0	0	
Other:	0	0	0	0	0	0	0	0	0	0	

Note: this handout was adapted from Thomas Ungar, MD, copyright, 2001. The activity was first presented at the faculty development conference "The Collaborative Mental Health Project, Ontario College of Family Physicians, Toronto, February 17, 2001." This exercise was successfully implemented as a reflection and discussion activity for teams.

Case 1

Name: Scott
Age: 14
Gender: Male
Setting: Suburban
Ethnicity: Caucasian

Care DeliverySettings Family physician's office,

school

Diagnosis: Anxiety disorder/Attention

deficit hyperactive

disorder/learning disability

Summary:

This is a case of an adolescent in a suburban setting presenting to the family physician with anxiety and suspected learning problems. Issues include: differences in expertise between specialist and generalist, diagnostic differences of opinion, attitudinal barriers and differences, roles and responsibilities for documentation and communication,

confidentiality, advocacy, family, and dominance of a team member.

Background:

Scott and his family have been in my medical practice for ten years. Scott is 14 years old, lives in a suburban community and attends junior high school. I have known Scott since he was four years old. He was a healthy child and a pretty normal kid, always pleasant and from a supportive family. I see him for his immunizations and regular complaints for the flu, or for bumps and bruises. He's an average student and gets along well with friends. He plays ice hockey, and soccer in the summer. He enjoys computer and video games, skateboarding and snowboarding. Since starting junior high he's been less interested in school. His parents attribute this to his being a teenager. Over the past four months Scott has become increasingly nervous about going to school. He started to skip classes. This has just come to the attention of his parents who received a call from the school.

Situation 1:

Earlier in the week Scott was sitting in class and became very nervous, started to breathe quickly, felt his heart was racing, and got sweaty and tremulous. The teacher noticed, thought he was having an allergic reaction, sent Scott to the office, and called Scott's parents. Apparently Scott has been having these episodes for several months before going to school but didn't tell anyone. Scott has come to see me accompanied by his mother. Scott's mother has given me a letter from the school requesting that Scott's health be assessed. They are asking for a note that he is well to be back at school.

Discussion 1

Communication

- 1. Discuss which team members can provide information in this situation.
- 2. What is the role of the family physician in responding to the school?
- 3. What are the possible diagnostic considerations in this case?
- 4. How can further information be gathered and whose responsibility is it to gather this?
- 5. What consultations, if any, can be initiated?
- 6. What form of note should the family physician provide the school at this point?

Situation 2:

Scott's physical examination is normal. Laboratory tests, including thyroid levels and blood sugar, are normal. His chest sounds clear and he has never had asthma to explain his shortness of breath. Scott does not have any allergies. He denies using street drugs or alcohol. He enjoys energy drinks like most of his friends. I have ordered cardiac testing to ensure that there are no arrhythmias but I think this is quite unlikely. I have treated Scott's mother for panic disorder in the past.

Scott tells me he has been feeling very nervous with upset stomach, especially on Sunday nights and Monday mornings. He says he really does not like his English, French and History teachers and sometimes he skips class. I think he is suffering from an anxiety disorder. I have referred him to our local Child and Adolescent Mental Health Teen Clinic. The waiting list is about six months. The parents are very upset about having to wait and want me to say it's urgent. I have advised the parents to get the school psychologist and guidance counsellor to see Scott in the meantime. Scott's mother has asked me to call the school but I have a busy office and don't have the time.

Discussion 2

Roles and responsibilities

- 1. What are the roles and responsibilities of a primary care provider?
- 2. What is a reasonable limitation to the primary care provider's involvement and expertise, and when should specialty consultations and referrals be initiated?
- 3. What is the role and responsibility of the family in advocating for resources, services and investigations?
- 4. What types of conflicts may arise between the family physician and family with respect to their frustration about lengthy waiting lists for an assessment?

Situation 3:

My name is Scott. I hate having my mother take me to the doctor. It makes me feel like she thinks I am a child. I don't see what the big deal is. A couple of my teachers are idiots, especially my English and History teachers. They are always angry and yelling at me saying I don't pay attention. They are really boring and so is the stuff we are learning about. I like phys-ed, shop and art class. Math is okay sometimes. I am not the only one who doesn't listen. I was really nervous that day in class that they sent me to the office. I

get nervous sometimes when I have to be in a crowded classroom, or bus, or at the mall when it's really busy. Now I have to go meet the guidance counsellor once a week. He's kind of cool. We talk about bands that I like, and a bit about girls. He wants to know why I'm not trying in class and why the teachers say I'm being difficult. He talks to my parents sometimes. I don't want to tell him too much because I don't want him telling my parents everything. I'm a little bit ashamed having to go see him. I am not going to tell my friends that I have to go see the school psychologist. They'll think I'm crazy. Anyways it doesn't really matter.

Discussion 3

Confidentiality

- 1. How can team members work with an adolescent patient/client and address specific needs around confidentiality?
- 2. How is the viewpoint of an adolescent patient/client taken into account?
- 3. What is the role of parent and guardian in the care of this person?

Situation 4:

I am Scott's mother. Scott is a wonderful person. He gets along with other kids and is great to have around. People like him a lot. He has always been an ok student and never really got in any trouble. We don't know what's going on and we're very concerned. Suddenly we are getting reports from the guidance counsellor and a couple of teachers that Scott seems to be uninterested and not trying hard enough. They think he is rebellious and refusing to do some of his assignments. They say at times he is not following directions in class. This doesn't sound like our son. Other teachers say he is doing quite well. He is still active on the school sports teams. He plays hockey and loves this. We go see his games and it's a lot of fun, but it is hard on us to drive him to the various tournaments.

We are very worried about his breathing and heart racing. Our family doctor has told us that everything is fine. She thinks it is anxiety or panic attacks. I don't think a family doctor has the expertise to diagnose anxiety in an adolescent. I had panic attacks years ago and I would feel awful if I passed it on to my son. My husband, Scott's father, thinks maybe we are being too lenient with Scott and should be stricter if he doesn't do his work. He has even talked about sending Scott to a different school if the problems continue. My husband and I disagree over this. We are really upset that it is going to take so long to get Scott assessed at the Teen Clinic. By that time Scott could lose his entire school year. We don't want that to happen. We have checked about the school psychologist but this is also going to be a long wait. My husband and I have an appointment at the school to talk to the principal to see if we can get the testing done sooner. We are also going to be calling our local school board trustee. My husband knows the trustee because they used to work together. My husband and I both work full time and it's hard to go to too many meetings.

Discussion 4

Communication - Family and caregivers

- 1. What is the role and responsibility of the parents in the care of this person?
- 2. How can the team help the family negotiate this situation?
- 3. How can the communication between parents be facilitated to prevent further conflict within the family?
- 4. How can the team help the family advocate for care and services for their son?
- 5. Consider a role-play exercise between team members, the parents and the patient/client.

Situation 5:

Scott was seen at the Child and Adolescent Mental Health Teen Clinic at the local hospital. He got an early appointment due to a last minute cancellation. Scott was seen by a mental health intake worker and by the clinic psychiatrist. Scott was diagnosed with panic attacks and mild social anxiety. The psychiatrist thinks that Scott's anxiety attacks and nervousness in classroom situations may have brought on the panic attack. Scott was recommended to get psychological testing either privately or from the school psychologist. Unfortunately, the clinic lost their psychologist as part of the hospital's restructuring a few years ago. The psychiatrist recommends medication and counselling. They will send a report to the family doctor with their recommendations but the clinic does not offer ongoing follow-up care.

When the parents spoke with the family physician she said she is not comfortable with medication treatment. She is frustrated that they do not follow patients/clients beyond the consultation. The family is very reluctant to try medication. They have concerns about the safety of the recommended anti-anxiety/antidepressant medications as they have read that they may cause suicide in teenagers. They will not start the medication at this time but are going to consider it. First, they want to consult with their community pharmacist to get an opinion and information about the drug treatment of panic disorder/seasonal affective disorder)

Discussion 5

Treatment options, ethics and patient advocacy

- 1. Whose responsibility is it to inform families of the risks versus benefits of various treatment options?
- 2. What happens when the team members differ in the treatment plan?
- 3. What is the area of expertise of various team members in this situation?
- 4. How can the family physician (or another primary care provider) and specialty services provider better work together for this person's well-being?
- 5. What are team members' ethics and values around access to resources such as waiting lists, and what methods can teams put in place to ensure equitable access to resources?
- 6. What is reasonable advocacy by families and persons with mental illness for access to resources and ongoing care?

Situation 6:

I am the school psychologist. I met Scott twice for two sessions of testing. He was further down the waiting list, but I guess the family pulled some strings and I was asked to see him sooner. He appears to have mild to moderate attention deficit disorder, inattentive type, with no evidence of hyperactivity, and a learning disability of auditory processing of information. He is better with visual spatial activities and has good fine and gross motor skills. I agree with the anxiety disorder diagnosis but the anxiety attacks are exacerbated and pronounced when Scott is asked to perform tasks that require focused verbal attention and concentration. His anxiety disorder further worsens his ability to focus and concentrate. I recommend academic accommodations and counselling to help Scott identify and manage his learning disabilities/deficits. I agree that helping Scott with his anxiety will also help his concentration and attention. I recommend he be excused from his regular class for special help sessions with our special needs education assistant.

Discussion 6

Communication and stigma

- 1. How can the team use this information on Scott's behalf?
- 2. Whose role and responsibility is it to implement the interventions as suggested by the school psychologist?
- 3. How will team members communicate information so that Scott's needs are met?
- 4. How might stigma about mental health/learning problems affect or limit Scott's interactions in the school and social environment?

Situation 7:

I am the school guidance counsellor. I've looked over the reports about Scott's learning disability and anxiety. We have lots of students with these problems. Scott's is a mild case. I'll try to explain the deficits to the teachers and get some form of remedial teaching assistance for Scott. His family has mixed feelings. They are happy that they've identified Scott's problem but are worried about how much our school can provide in terms of

assistance. The most I can get him is twice a week, half an hour session with the educational assistant. I'm worried the other students will tease Scott if they see him go for special help. His parents say the doctor recommends medication but they're hesitant and want to first see what the remedial assistance will do. I think Scott should try the Ritalin and the anxiety medicine. I've seen lots of our students do much better once they're on the right medication. What do they expect us to do if they don't take the advice they've been given? I hate to see a good kid's future ruined just because parents get in the way. I'll try and impress upon his parents that if they don't intervene and act soon, Scott may end up in a different educational stream or in trouble with the law. I've seen it all too often. I really like this kid and I'm going to make it my mission to get him the help he needs.

Discussion 7

Attitudes and feelings

- 1. What are team members' attitudes and feelings about using medications for mental health problems in children and adolescents?
- 2. How can team members ensure that treatment decisions are based on the best available evidence for outcomes and not only on attitudes?
- 3. How can the team continue to support and work with this person and family?
- 4. What role can the school and community play in the prevention of mental health problems?
- 5. How does a team cope with a dominant member who may try to take over?

Case 2

Name: GloriaAge: 24Gender: FemaleSetting: Rural

Race: First Nations

Care Delivery Setting: Community shelter Diagnosis: Substance abuse

Perspective: Consumer

Characters: Peter (spiritual elder), Mary

(addictions counsellor), and

Jill (social worker)

Summary:

This is a person with substance abuse and self-harm problems. Issues include: culture and family, a remote community setting, team conflict over roles, responsibilities and differing team member values, stigma, communication, and responsibility for recovery.

Background:

My name is Gloria and I'm 24 years old. I grew up on a reserve (near Norway House). My father used to

drink a lot, and died when I was eight years old. One night he drank too much and fell asleep outside in the winter and was found dead. I lived with my mother and six brothers and sisters. I've been drinking since I was about 12 years old. My older brothers and sisters would often buy booze. Sometimes we would sniff gasoline. We went to school until about grade 8 and then dropped out. My mother has become a born-again Christian over the past few years. She goes to the community church meeting every Sunday and is always praying for us. I'm not interested in the church and we often have a lot of arguments and fights.

Sometimes when I feel very upset I cut myself out of frustration. I used to do this more often when I was a teenager but haven't had to do it as much lately. I drink about twice a week until I pass out. Back home, I had an addictions worker that I was supposed to see regularly. Sometimes I refused to see him. He was nice but I had trouble stopping the alcohol for more than two weeks at a time. Once a month a nurse practitioner or a doctor would come to visit my community. The doctor told me I was overweight, that my liver tests were too high and that I should eat better and stop abusing the alcohol. I wasn't able to do this.

One month ago I decided to leave home and moved to a small town about six hours away. Since I had nowhere to stay, I am now staying at a women's shelter. There is a native community centre and a small community health clinic nearby. I started going to meetings at the native centre where Peter (a spiritual elder) has been meeting with me. I'm very interested in my traditions and like to hear about my culture's background and history. I don't believe in the "born-again" stuff my mother preaches. I like my traditions much better, like what my grandmother used to teach me.

Situation 1:

Last weekend I drank too much and passed out at the women's shelter. The women's shelter has told me if that I get drunk again they are going to ask me to leave. They will let me stay only if I go to meet with a health team at the health centre. I don't want to go but I have nowhere else to stay. People at the meeting are going to be a family doctor, an addictions worker, a community mental health nurse, and a social worker. They asked if I had any family who could attend the meeting.

Discussion 1

Care planning - Roles and responsibilities

- 1. Discuss a care plan for this person focussing on the perspective of the patient/client in her recovery.
- 2. What are the roles and what does each team member have to potentially offer this patient/client?
- 3. Consider what other team members/individuals you might involve in the care of this patient/client.

Situation 2:

I've been meeting with Mary, the addictions counsellor, twice a week. She thinks I might be depressed and wants me to see a psychiatrist who visits our community once every two months. I met the social worker who is trying to help me get financial help for local housing; the housing forms need a doctor/nurse or addiction counsellor to sign them to say that I'm not using drugs or alcohol. I met with the psychiatrist who said she could not decide if I was depressed unless I was clean and sober for two months. It's only been a couple of weeks. Jill, my social worker, can't submit the forms until they are signed. The doctor, nurse and counsellor won't sign the forms until I'm clean and sober for two months. I'm mad and don't understand why they won't sign the forms. I'm trying to change my life and I am doing what they ask of me.

Discussion 2

Conflict resolution

- 1. How can the team help this person?
- 2. What types of conflict and communication problems can arise between team members in this situation? How might you resolve these?
- 3. Consider a role-play activity between the housing or social worker and the health care professionals who are required to sign the forms and negotiate a solution to this problem.

Situation 3:

It's been two months. I've been clean and sober and the team has signed the forms. I met with the psychiatrist who gave me antidepressants when she came back to town. She thinks the reason I cut myself might be because I am depressed. The antidepressants are making me feel sick to my stomach and I don't like them. I trust Peter, my spiritual elder

at the health centre, the most. He's good, but I didn't tell him about my sexual abuse when I was a child. When my father would drink, sometimes he would abuse us physically and sometimes sexually. Also, I think I am gay. I never before told anyone and felt I had to get away from home and my community.

Jill wants to contact my mother to arrange a family meeting and obtain information about my past. I signed the consent forms. I'm worried. I told the mental health nurse about my being gay when I met with her. I'm worried Jill could tell my family.

Discussion 3

Communication - Structures, resources and culture

Note: Issues around sexual orientation are not always widely understood or discussed; there may be gaps in the participant's understanding of how to address these concerns. If needed, ask the workshop facilitator for clarification or information to supplement this discussion.

- 1. Discuss record keeping and how team members communicate and maintain confidentiality amongst each other.
- 2. What further resources or ways could this team help this patient/client?
- 3. How does the patient/client's culture affect the team's work in helping her recovery?

Situation 4:

I drank again. I was upset because my mother came over and wanted me to go to church and I had a big argument with her. I went out and got drunk. When I came back to the shelter the next morning, they told me to leave. I called Mary, my addictions counsellor, who wants to meet me tomorrow and wants to help me. Jill told me that the rules for staying at the shelter were clear and that I broke them. They can't do anything for me right now. The doctor won't give me more antidepressants because I drank. I thought the antidepressants were helping me feel better. Mary told me the doctor is being a jerk.

Discussion 4

Conflict resolution – Treatment options

- 1. Discuss team conflict over the treatment plan and how to respond to the client/patient's alcohol use.
- 2. What framework and values do team members bring to the treatment of a patient/client with substance abuse?
- 3. How can the team be of most help to the patient/client?
- 4. Consider role-play of conflict over differing positions about abstinence versus a harm reduction model?
- 5. Explain/demonstrate how to resolve the conflict situation when one team member has spoken poorly about another.

Situation 5:

I've been doing well for the last three months. I've been clean and sober and have a room in a boarding house. The native community centre gave me a part-time job with the help of Jill. I told the people in my support group that I thought I was gay. Members of my health care team have been supportive, but I think the nurse practitioner is upset with me about this. I don't think she likes gay people. Someone in my group went back to the community where my mother lives and told the people that I'm gay. My mother is very upset and doesn't want to talk to me. I'm okay with that. I almost drank again yesterday, but I met with Mary who helped me. I don't know if I'll be able to stay clean. I stopped taking the antidepressants. I don't know if it was helping. Yesterday I cut my forearm. I don't know why I did that but felt a bit better after. At least I didn't drink.

Discussion 5

Patients/clients, families and caregivers - Roles Personal biases

- 1. What is the patient/client's role in her recovery?
- 2. How can the team help with a support network and family relationships?
- 3. Can the team offer any support to family members?
- 4. What is the role of team members in their availability and appointments?
- 5. How would a team deal with one member whose value system may preclude him/her from working with a patient/client due to personal, racial or stereotypical prejudicial beliefs?
- 6. Consider role-playing how a team would handle a team member who is uncomfortable or unwilling to work with a patient/client.

Case 3

Name: Hazel
Age: 84
Gender: Female
Setting: Small town
Ethnicity: South Asian
Care Delivery Settings: Home, hospital
Diagnosis: Dementia
Perspective: Family

Summary:

This is a case of an older person with dementia who becomes less able to function in the community. The family and team develop differences of opinion over safety and getting resources to facilitate optimal placement for the older person. Issues include: power, advocacy, family, team disagreement, safety, resources, and conflict resolution.

Background:

My mother is 84 years old. She is widowed and lives on her own in the small bungalow we grew up in. She and my father brought us to Canada when I was a child. They ran a small convenience store in town and were very successful, hardworking people. I have grown up in this town and my children have grown up here. They are in high school. For the past five years my mother has been declining. Her memory has been failing and she has needed more and more help. At first I was able to help her with shopping and cleaning and the kids could help with shovelling the snow and doing the garden, but this is no longer enough. Three years ago with the help of our family doctor we had a geriatric public health nurse and geriatric assessment workers come to the home to help my mother. They tacked down the carpet, installed handrails and got her a panic buzzer. But over the past few years things have continued to get worse. She has been hospitalized twice after she got confused and forgot to take her proper medications. She also has high blood pressure and arthritis. My husband and I are busy working and raising the kids and do not have time to constantly take care of her. We do not have room for her to move in with us, and I feel guilty about that. She is on a government pension and just able to get by. We cannot afford a private care worker.

The visiting nurse and care attendants come to see her twice a week. Last time when they arrived they found that she had left the electric kettle on and there was only about a half inch of water left before it went dry. She had not heard the kettle whistling and seemed confused and disoriented. They noticed she had not gotten herself properly dressed, seemed very confused. They called an ambulance and she was taken to the hospital. The doctors diagnosed her with acute confusion and worsening of her dementia. They noticed she required more care than she had before and were concerned about her ability to manage for herself at home.

Situation 1:

At the team meeting we were asked to sign applications to have her placed in a nursing home. We do not want her in a nursing home. Those are terrible places and we would like to do everything possible to keep her from having to go there. She always told us she wanted to stay in her own house until she passed away. No matter what, we will not sign these papers. The recreation therapist and the occupational therapist told us that there are behavioural rehabilitation programs for people like my mother. We would like her to try this. Also we would like to see if she could have further home care, which the team says could be arranged. But the hospital has a policy that in order to obtain behavioural retraining and get further supports in the home we must apply and be on the waiting list for a nursing home. We do not want to do this and do not understand why we cannot get these services. We have lived our entire adult lives paying taxes and feel we should be allowed to have these supports. Half the nurses, one of the doctors and the social worker think my mother might be unsafe to be at home and want her put in a nursing home. The other half of the nurses, the occupational therapist and the recreation therapist think that with some behavioural training she may be able to go home with visiting supports.

Discussion 1

Managing multiple perspectives and demands

- 1. Discuss resolution to this situation with differing opinions on placement requirements for this older person.
- 2. Consider a role-play exercise between team members with differing opinions with respect to the patient/client's safety.
- 3. How can team members resolve conflict and improve communication with the family and their requests and demands?
- 4. How might the cultural background of the family affect the team's approach?
- 5. How can the team's care plan solve an administrative hurdle such as requirement of an application form being signed before the patient/client can have access to the requested services?
- 6. What role can the various team members play in designing a treatment plan for this person?

Situation 2:

After a lot of arguing and phone calls the team has backed off on their request for us to sign nursing home applications. The team spoke to the hospital administration and got special permission to override their hospital policy and will allow my mother to get behavioural rehabilitation. My mother is back on her regular medications and the doctor started her on a new medicine, a low dose of an anti-psychotic medicine to help her behaviour. I do not like her on psychiatric medication but I guess I have no choice. The pharmacist gave me a computer print out which explained the side effects of the antipsychotic medication, including that older people have an increased risk of strokes and of dying when taking them. I am very angry with the doctor for not telling me about this and am glad that at least the pharmacist is looking out for my mother. I have asked

for a meeting, but the doctor will not be available until three days from now. In the meantime I have asked them to stop giving my mother that anti-psychotic medication. The nurses are very angry with me and say my mother has been up more at night and might have to go to a nursing home if I do not let her take that medication. I feel like I am being blackmailed. I do not know what to do. I think I may call the patient advocate office of the hospital to see if they can help me.

Discussion 2

Communicating with patients/clients, families and caregivers; and Stigma

- 1. Discuss how a treatment plan, including medication risks and side effects, are communicated to patients/clients and family members.
- 2. How can a patient/client or family's idealization and devaluation of the team members be approached by the team?
- 3. How can the team better work with this family member to reduce conflict?
- 4. How does stigma affect this family and patient/client with respect to her now being prescribed a psychiatric medication?
- 5. Consider a role-play exercise involving team members, the family and the patient/client.

Situation 3:

After meeting with the doctor and the pharmacist I now see that the medicine may be helpful despite some risks. We agreed to try it for a week and she is actually doing better. The nursing team seems to be more supportive when I visit. The recreation therapist and occupational therapist tell me that she is starting to improve with the therapy and supports they are providing. The social worker is arranging to have an increase in visiting supports in the house so that we get a care worker coming in every day to help and check on my mother. Also she will be able to attend the geriatric day program at our local community centre three times per week. I will be able to go in and visit her on my way home from work on the other days, and the rest of our family will try to check in on her on the weekends. I hope this helps. It's much nicer not to be fighting with the health care workers. I hope my mother never has to go to a nursing home, but I recognize she may need more care in the future.

Discussion 3

Decision making and power

- 1. Discuss each team member's attitudes and model for including patients/clients and family in care and recovery decision making.
- 2. Discuss team differences in power for making various care decisions.
- 3. Discuss team members' attitudes and feelings about residential placement of patients/clients with mental health problems versus community care.
- 4. Do team members from different disciplines take into account the costs and resource requirements of patient/client treatment plans?

Case 4

Name:StanAge:43Gender:MaleSetting:UrbanEthnicity:CaucasianCare Delivery Setting:HospitalDiagnosis:Schizophrenia

hospital-based team

Clinical care

Summary:

This case involves a person with a relapse of chronic schizophrenia, readmitted from the community through the hospital crisis service to the inpatient psychiatric unit. While admitted the care team develops differing views of the person's dangerousness and how best to care for him. Some of the issues highlighted include: safety and dangerousness, team disagreement, communication, team roles

and responsibilities, family, advocacy, stigma and discharge planning.

Background:

Perspective:

Stan is 43 years old with a long history of schizophrenia. He has had numerous hospital admissions for his illness and is well known to the hospital and community team in his local region. For the most part he has been well and has been receiving care in an outpatient setting. He visits the hospital once a month to see his psychiatrist for prescriptions of his maintenance medication. He lives in a rooming house and has a community mental health worker who meets him every second week. Stan obtains medication through a local pharmacy that provides him with blister-pack medications. Stan has met with a dietitian in the past about his frustrations with his weight gain and elevated blood sugars.

With the assistance of the hospital social worker and clinical team, he has been on government disability benefits for over ten years. He sees a family physician at his local community health clinic. He attends a local peer support centre where he drops in to participate in social activities. He is well known to the peer support worker and recreational therapist in the program. He has a sister living in a town three hours away whom he visits twice a year for holidays such as Christmas. His mother lives in a retirement residence and his father has passed away. His mother's health is compromised and she uses a walker. She had been very involved with Stan as a primary caregiver for many years. She moved into the retirement residence five years ago and has had less direct involvement with him. She no longer comes with him for his hospital appointments.

Stan is well known and well liked by clinical team members who have worked with him. When well, he is pleasant, has a good sense of humour and often will come an hour early for his appointments. He enjoys socializing with the receptionists and team members at the hospital clinic and with other consumers/survivors at his peer support group. When well, he enjoys volunteering at the peer support centre during holiday food drives and

special events. With the help of his vocational rehabilitation counsellor he obtained a parttime job at his rooming house, where he is responsible for maintaining the grounds, hallways and stairwells. This takes him about three hours per week for which he is paid a small amount that does not jeopardize his disability support. Stan is generally well liked by people in the rooming house, both landlord and residents.

Situation 1:

You are called to a team meeting regarding Stan. He was admitted three days ago through the Crisis Service. He has threatened a new part-time nurse on the elevator calling her a "whore" and telling her "to watch out." The nurse has kept this to herself for two days, unsure if it was of concern. Most of the clinical inpatient hospital team know Stan quite well and, despite his being ill, seem very tolerant of his disturbed paranoid behaviour and language. A team meeting has been called with respect to how to manage Stan's behaviour and how to deal with the threat to the new part-time nurse.

Discussion 1

Theoretical and problem-solving frameworks

- 1. Attempt to have team members make explicit their theoretical and problem-solving frameworks from which they begin thinking about this clinical situation.
- 2. Have team members explain their theoretical frameworks and models to team members from other disciplines who may be unfamiliar with these.
- 3. Discuss and make explicit each team member's feelings and attitudes about the person's threats and behaviours, and how to manage these.

Situation 2:

The team gathered the following information: Stan had stopped taking his medication. The pharmacist reports that Stan did not pick up his blister packages of routine medicines three weeks ago. The pharmacist had phoned and left a message with the patient/client's psychiatrist on the answering machine. However, the psychiatrist does not answer the phone directly and had not returned the call. The patient/client's visiting community health nurse reports that she had visited Stan and noticed he was becoming a bit more suspicious and hostile. But he claimed to be taking his medicine and she did not check with the pharmacy. The psychiatrist reports that two weeks ago Stan had not shown up for a routine scheduled monthly appointment. Stan's mother reported that she started becoming concerned that Stan was becoming ill, as he had started calling her complaining about his sister. This was often a sign of his declining mental health. His mother was unsure who to contact or what to do.

Discussion 2

Roles and responsibilities

Take this opportunity to begin to discuss roles and responsibilities in respect to this case.

- 1. Whose role is it to monitor the medication?
- 2. Who can the family call if they are concerned about Stan's health declining?
- 3. How do team members communicate with one another?
- 4. Who is responsible for monitoring missed appointments or prescriptions that have not been obtained?
- 5. What methods do team members use to communicate with one another? Telephone? Fax? E-mail?
- 6. Who can assess and intervene in the community prior to prevent the decline in mental health?
- 7. What feelings do team members have about each other's responsibilities? Who did or did not do their job? How will this affect team relationships when working with each other?
- 8. Consider a role-play exercise between team members' disagreement over roles and responsibilities.

Situation 3:

During the team meeting the following information is reviewed: Stan has once again become paranoid, which is his main symptom when unwell. He thinks that his sister, people around him, members in the community and care providers are against him and are trying to prevent him from living his life. Over the last few weeks he has become increasingly concerned that a parked car across the street from his residence is watching him. He thinks they have been hired by his sister to keep tabs on him. Stan became concerned that people at the local donut shop were members of his sister's spy network. He became belligerent and began arguing with a customer in the donut shop. He threatened that if the customer did not admit that he worked for his sister that he was going to have to take him outside and beat a confession out of him. At that point, the donut shop owner had called the police.

Stan was brought by police to the local hospital Emergency Room and was seen by the crisis worker. The Emergency Room family physician saw him but did not want to do a physical examination, as he seemed belligerent and very hostile. The Emergency Room physician had the crisis worker refer Stan to the psychiatrist. Stan's mother was contacted but she had no transportation to get to the hospital Emergency Room. Over the telephone she expressed concern that Stan's physical health be checked as he has had elevated blood sugars. She asked that it be checked.

Discussion 3

Roles, responsibilities, record keeping, stigma

Use this opportunity to discuss the role of family members in a crisis situation.

- 1. How and when are family members contacted and how is their input used?
- 2. What information is available to the team in crisis situations, including past history, medications and medical problems? Who is responsible for obtaining this information? What method of information and record keeping does the team use?
- 3. Discuss stigma that mental health patients/clients face when seeking or obtaining medical examinations and related care services.

Situation 4:

The crisis worker spoke with the on-call psychiatrist over the telephone. Stan was admitted to the psychiatric unit and certified as an involuntary patient. He was given his regular medication, which he reluctantly accepted. He was unusually verbal, irritable and belligerent. But Stan is well known to the crisis worker, and the clinical team on the unit was relatively tolerant of his behaviour. They knew him when he was well and had seen him get well on previous admissions, usually over a period of about four or five days. He was not threatening to harm himself or specifically to hurt anyone but was somewhat hostile and angry. He asked to leave the unit for cigarettes but was not allowed due to his involuntary status and staffing shortages. He was visited by a patient advocate and informed of his rights. His mother telephoned and expressed concern about Stan's well-being and spoke to the nurse in charge.

Discussion 4

Patient advocacy and power differentials

- 1. How does the team ensure advocacy for patients/clients when involuntarily certified?
- 2. Who advocates for patients/clients in the community?
- 3. What are the barriers to obtaining rights and advocacy when unwell?
- 4. Discuss power differentials in the relationships between the patient/client and the team when rights are compromised due to involuntary certification.
- 5. Discuss power differentials when patients/clients are unwell.

Situation 5:

A team disagreement developed on the inpatient unit. Several nurses and the psychologist, who had seen Stan on previous admissions, knew him and felt it unnecessary to have him under involuntary certification. They wanted to allow him out for a smoke and said he was "harmless." At times Stan would come to the nursing station and accuse members of the team of spying on him and purposely wanting to keep him in hospital so that his sister could steal things from his apartment. Nevertheless, the team was comfortable and certain he would get well and be discharged in a few days as usual. By the third day of admission he was allowed outside for a cigarette accompanied by a nurse. He had done so with few problems. Eventually a new part-time nurse was

assigned to accompany him outside for a cigarette. The nurse later reported that he threatened her telling her to "watch out" and to "tell my sister I'm not going to let her get away with anything." At first she kept this to herself. She was concerned and worried but noticed the rest of nurses and team were very comfortable with Stan and said he was "harmless." She felt she would be seen as weak and poorly thought of if she said anything. She eventually broke down crying one day with one of the other nurses and was encouraged to report the threats to the nurse in charge.

Stan's threats were reported to the psychiatrist and seclusion was ordered for him overnight until the team could meet to discuss the threat. Many members of the team were upset to see Stan secluded. He was starting to get better and they did not understand the seclusion at this point in his admission. The team was split between those who felt the nurse in charge and psychiatrist were being overly punitive and those who supported the order and were on the part-time nurse's side. A senior full-time nurse, who had previously worked with Stan, phoned his mother and encouraged her to come in and find out what was going on and protect him. She told the mother she disagreed with the seclusion order.

Discussion 5

Conflict resolution

- 1. Discuss how team conflicts can be resolved in the care of this patient/client.
- 2. When teams are split, how is this identified, communicated and what process is invoked?
- 3. Discuss differences in power relationships in terms of clinical decisions and clinical orders
- 4. How do team members proceed when they disagree with a decision, yet have limited power to change the situation?
- 5. What power do families have in team relationships, and how can they communicate their positions during disagreements and conflicts?

Situation 6:

Stan's mother arrived the next day asking for a meeting. She was concerned that the team may think her son is a bad person and wanted to express to them that he is a good, kind person and would get better. She required transportation from her retirement residence to the hospital to meet with the team and had made special arrangements with a fixed return transportation time. She became upset when the team was late for the meeting. Her driver was unwilling to wait and was very concerned that she not be transporting her son. The driver did not want any mentally ill people in his vehicle.

Discussion 6

Communication and stigma

- 1. How can team and family communication be facilitated?
- 2. How are family meetings and input arranged and how can the team be responsive to the clinical needs of family?
- 3. Discuss stigma for family members, patients/clients and clinical staff in treating the person with mental health problems.

Situation 7:

The team met to discuss the clinical case and how to manage the threats. Eventually the team agreed upon a consistent plan that everyone, including the family, was asked to follow. A single reporting mechanism for threatening outbursts was enacted by the team. Within a couple of days Stan responded to the clinical management and he returned to his normal self. He was allowed out unaccompanied and became a voluntary patient. Discharge planning proceeded and a discharge plan was agreed upon and put in place.

Discussion 7

Discharge treatment plan

Discuss a discharge treatment plan for Stan.

- 1. What communication systems can be put into place should he require care again?
- 2. Who can the family contact?
- 3. Who can monitor Stan in the community?
- 4. What role does Stan play in the plan and in his recovery?
- 5. What best practices can be put in place?
- 6. How can the team help Stan reintegrate into his community peer support group, housing and social environment?
- 7. What supports can assist the family role in the care and recovery? What are the barriers to the patient/client and family's involvement?

Workshop debrief

Facilitator Instructions

Before beginning the discussion, have the participants answer the following questions on a sheet of paper:

- 1. What are the three best ideas that you got out of the day?
- 2. What are three misconceptions that you had about other team members?
- 3. What are three things you learned about other team members?

Have participants share what they have learned during the workshop and express any additional questions or concerns that

they may have. Consider the following questions:

Workshop Debrief: Objectives

- To gather feedback from the participants about their experiences
- To provide closure about the events of the workshop
- To identify any next steps in implementing what was learned in the workshop

Time: 40 minutes

Materials:

- Markers
- Flipchart
- 1. How has your perspective changed about working in an interprofessional team environment?
- 2. How has your understanding about the roles of other professionals/team members changed?
- 3. What are some of the benefits in working in an interprofessional team? To you? To other professionals/team members? To patient/clients, their families and caregivers?
- 4. What was one area, experience, or idea that you felt challenged by today? Why? What did you learn?
- 5. What was one stereotype or belief about interprofessional education or collaborative mental health care that was challenged today?

Identify next steps regarding how the information learned today might be implemented in the future. Consider the following questions:

- 1. How might you incorporate the principles and concepts of interprofessional education and collaborative mental health care into your current activities?
- 2. What other professionals/team members might you consider collaborating with in the future?
- 3. How might you encourage other colleagues to learn about the benefits of interprofessional education and collaborative mental health care?
- 4. How might you support and encourage the involvement of consumers, families and caregivers in your current interprofessional education and/or collaborative mental health care activities?



Evaluation

Workshop Evaluation Handout

Base your ratings on your expectations for courses/workshops of a similar type and size. Please rate each item independently of the others by circling the number that best fits your perception.

Item Scale								
	1 – strongly disagree2 – disagree3 – somewhat disagree4 – neither agree nor disagree				5 – somewhat agree 6 – agree 7 – strongly agree N/A – not applicable			
The course outline or other course descriptive information provided enough detail about the course	1	2	3	4	5	6	7	N/A
The course, as delivered, followed the outline and other course descriptive information	1	2	3	4	5	6	7	
The course content was presented in a well-organized manner	1	2	3	4	5	6	7	
4. Participant questions and comments were responded to appropriately	1	2	3	4	5	6	7	
5. The course content was communicated with enthusiasm	1	2	3	4	5	6	7	
6. Participants were treated respectfully	1	2	3	4	5	6	7	
7. I learned a lot at this course	1	2	3	4	5	6	7	
8. The support materials (e.g., readings, audio-visual materials, speakers, equipment, software, etc.) used in this course helped me	1	2	3	4	5	6	7	
9. Overall, I was satisfied with the course	1	2	3	4	5	6	7	
10. The "social" component of this program (i.e., meal, coffee break, venue, etc.) did not interfere with my learning	1	2	3	4	5	6	7	
11. There was no evidence of industry bias or intrusion on my learning	1	2	3	4	5	6	7	
12. This program was ethical and balanced	1	2	3	4	5	6	7	

Note: this was modified from University of Calgary, available at http://www.rcpsc.org.



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Appendix A: Glossary of terms and Index of acronyms

Glossary of terms

Best practices – Activities and programs that are in keeping with the best possible evidence about what works [interchangeable with "Better Practices," "Positive Practices" and "Good Practices"] (Health Canada, 1998).

Chronic disease management (CDM) – A systematic approach to improving health care for people with chronic disease that emphasizes helping individuals maintain independence and keep as healthy as possible through prevention, early detection and management of chronic conditions (British Columbia, Ministry of Health Services, 2004).

Collaborative primary health care – The delivery of services at the first point of contact with the health system by two or more different stakeholders (health professionals, consumers, families, primary health care organizations, community agencies) working together in a partnership that is characterized by:

- common goals or purpose;
- a recognition of and respect for respective strengths and differences;
- equitable and effective decision making;
- clear and regular communication;

in order to:

- improve access to a comprehensive range of services (treatment, health promotion, disease and injury prevention and management of chronic diseases and self-help), delivered by the most appropriate provider in the most suitable location;
- deliver high quality and effective health care;
- make the most efficient use of resources;
- improve outcomes for the consumer.

Consumer – A recipient of health care and related support services to meet the individual's needs in any care setting [interchangeable terms include patient, user, client.].²

Consumer-centred – Care that is respectful and responsive of individual patient preferences, needs and values; ensuring that patient values guide all clinical decisions.³

² Adapted from: Canadian Medical Association; Canadian Nurses Association. Working together: a joint CNA/CMA collaborative practice project. HIV/AIDS example [background paper]. Ottawa: CMA; 1996. p. 24.

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Determinants of health – Factors in an individual's living and working environment that can affect their health (e.g., housing, education, income, employment, culture, physical environment, equity).

Health promotion – The process of enabling people to increase control over and to improve their health (WHO, 1986).

Interdisciplinary – A range of collaborative activities undertaken by a team of two or more individuals from varying disciplines applying the methods and approaches of their respective disciplines.

Interprofessional education – Occasions when two or more professions learn from and about each other to improve collaboration and the quality of care.

Mental health promotion – The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health (Health Canada, 1998).

Mental health specialist – An individual with mental health expertise, be it related to health promotion, prevention, diagnosis, treatment or rehabilitation.

Post-licensure – Continuing education for health care professionals.

Pre-licensure – Undergraduate and graduate-level training.

Prevention – Interventions that target risk factors for specific illnesses in order to prevent the initial occurrence of a disease, arrest or retard an existing disease and its effects, or reduce the occurrence of relapses.

Primary health care – An individual's first contact with the health system characterized by a spectrum of comprehensive, coordinated and continuous health care services such as health promotion, diagnosis, treatment and chronic disease management.

Primary mental health care – Mental health services provided in a primary health care setting. Settings where primary health care can be delivered include the offices of health care providers, community clinics, workplaces, schools, homes, health care institutions, homes for the aged, nursing homes and day care centres. Primary mental health care may also be available by telephone, health information services and the Internet.

Recovery – A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Index of acronyms

ACT Team Assertive Community Treatment (ACT) Team

CCMHI Canadian Collaborative Mental Health Initiative

CDM Chronic disease management

EAP Employee Assistance Programs

NNADAP Native Alcohol and Drug Abuse Prevention

WHO World Health Organization



Appendix B: Decision guide

Is an interprofessional education program right for you?

While interprofessional education in the context of collaborative mental health care creates benefits for students, faculty, health care professionals, and the health system, a site or institution considering the introduction of an education program needs to ask itself, "When do the benefits of teaming outweigh the barriers?" Consider an interprofessional education approach when the following are characteristics of your situation (Tsukuda, 1990):

- 1. The problem is complex enough to require more than one set of skills and knowledge.
- 2. The amount of relevant knowledge or skills is so great that no one person can posses them all.
- 3. Assembling a group with more than one set of knowledge or skills will enhance the solution of the problem.
- 4. Those individuals possessing the necessary skills or knowledge are capable of acting as equals.
- 5. The individuals involved are working toward a common goal for which they are willing to take joint responsibility.
- 6. High-functioning teams can reach a level of synergy that enhances their efficiency and effectiveness.

Is your university or school ready for an interprofessional education program?

The following is a checklist designed to help you determine whether your university or school is ready to introduce an interprofessional education experience. The checklist is only a guide, but is useful as a faculty exercise to be certain those involved have similar beliefs from the outset. Consider the following:

	Do health care policy trends at the national, provincial, or local level indicate a need
	for changing the way your graduates provide collaborative mental health team care?
	Does your university have a vision or goal for the kind of care it wants graduates to provide to its mental health consumers?
Q	Would your university welcome an initiative that developed interprofessional team care curricula and clinical experiences in collaborative mental health practice?
	Does your university have faculty on board who are committed to improving
	interprofessional education and possess the knowledge and leadership skills to move a collaborative mental health curriculum forward?

Is your university willing to undertake a curriculum assessment that may lead to major change?
Can you generate support among a critical number (for example, three to four) faculty/leaders for improving collaborative mental health team training curricula?
Is your administration committed to improving interprofessional education curricula and care?
Is your administration willing to dedicate the resources to carry out the changes necessary to improve curricula and training?
Are faculty leaders at your university willing to dedicate the time necessary to adapt innovations in collaborative mental health education curricula to make them their own?
Do you have appropriate faculty and clinical faculty who could help develop curricula?
Is there an academic leader willing to take on the day-to-day leadership and coordination of a new program on interprofessional education?
Can you name the educational unit willing to take a lead in improving interprofessional education curricula?
Will the faculty members have the necessary strength to keep all related faculties involved and motivated?

Additional Information Resources

There are several funded initiatives and centres or organizations of excellence that may assist you in developing, implementing or evaluating your interprofessional education program.

Funded Initiatives

- Primary Health Care Transition Fund: Fostering Initiatives in Collaborative Practice
 and Interprofessional Education. There are five initiatives that form the basis of the
 national collaborative care strategy (http://www.hc-sc.gc.ca/hcs-sss/prim/index_e.html):
 - The Canadian Collaborative Mental Health Initiative: www.ccmhi.ca
 - e-Therapeutics Drug Therapy Management:
 http://www.pharmacists.ca/content/about_cpha/whats_happening/cpha_in_action/etherapeutics.cfm
 - Enhancing Interdisciplinary Collaboration in Primary Health Care: http://www.eicp.ca
 - The Canadian Nurse Practitioner Initiative: http://www.cna-nurses.ca/cna/
 - The Multidisciplinary Collaborative Primary Maternity Care: http://www.mcp2.ca/

- Another key initiative funded through the PHCTF is the project Building a Better Tomorrow: Engaging Current Providers in a Renewed Primary Health Care System for Atlantic Canada (http://www.hc-sc.gc.ca/hcs-sss/prim/phctf-fassp/init/multi-atlanti_e.html).
- The Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) Initiative is part of Health Canada's Pan-Canadian Health Human Resource Strategy. http://www.health-human-resources.ca

Centres, Networks and Other Organizations

- Ontario Centre for Collaborative Care: nkates@mcmaster.ca
- Centre for Collaborative Health Professional Education: http://www.med.mun.ca/cchpe/
- Interprofessional Continuing Education: http://www.interprofessional.ubc.ca
- Tri-Interprofessional Learning: http://ipl.dal.ca/index.html
- Interprofessional Education at the University of Toronto: http://ipe.utoronto.ca/index.html



Toolkit Series

This toolkit belongs to a series of twelve toolkits.

Implementation toolkits for providers and planners

1. Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners.

A series of companion documents to the CCMHI planning and implementation Toolkit for health care providers and planners. Establishing collaborative initiatives between mental health and primary care services for:

- 2. Aboriginal peoples
- 3. Children and adolescents
- 4. Ethnocultural populations
- 5. Individuals with serious mental illness
- 6. Individuals with substance use disorders
- 7. Rural and isolated populations
- 8. Seniors
- 9. Urban marginalized populations

Toolkits for consumers, families and caregivers

- 10. Working together towards recovery: Consumers, families, caregivers, and providers
- 11. Pathways to healing: A mental health guide for First Nations people

A Toolkit for Educators

12. Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators

A series of documents examining aspects of collaborative mental health care support these toolkits:

Barriers and strategies International initiatives [unpublished] A framework Health human resources 2. 8. 3. Annotated bibliography 9. Mental health prevalence and utilization Better practices 4. 10. Interprofessional education Canadian initiatives Aboriginal mental health [unpublished] 11. A policy review 12. The state of collaborative mental health care

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