

An Exploration of Perceptions of Interprofessional  
Collaboration and Rural Mental Health

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## Abstract

Interprofessional collaborative practice has been found to have benefits both for patient/client care and for health professionals (Baggs & Schmitt, 1997; Zwarenstein et al., 2005; Zwarenstein & Bryant, 2000; D'Amour et al., 2005; Henneman et al., 1995). Most of this research has been conducted in urban settings and few studies have examined how working in teams may function to treat mental health in rural communities. There are a number of challenges to working in rural communities: a shortage of health care professionals, low resources, high turn over rates, elevated feelings of burnout, minimal social support, job dissatisfaction, and geographical and transportation issues (Hutten-Czapski, 2001; Kee, Johnson & Hunt, 2002; Sutton & Patterson, 2002; Thorngren, 2003; Barbopoulos & Clark, 2003). Interprofessional collaboration may offer a means of addressing the challenges faced by rural communities because working with other professionals may increase professional satisfaction and reduce feelings of isolation and burnout. This thesis research project had two foci, first, to examine perceptions of interprofessional collaboration among health care professionals working in a rural area, and second, to explore the factors associated with treating mental health in a rural community.

The setting for this research was a rural community in Newfoundland. Twelve health care professionals participated in this study: a guidance counsellor, a youth worker, three social workers, a police officer, a family physician, a community health nurse, a mental health counsellor, an occupational therapist, and two nurse practitioners. Qualitative methodology was used for the research design and all professionals participated in face-to-face interviews.

Participants strongly endorsed the value of interprofessional collaboration in treating mental health issues in their community. They identified benefits for patients/clients such as enhanced quality of care. Professionals also identified increased support, feeling valued and respected, and improved decision-making as benefits for them professionally. Participants saw teamwork as advantageous in treating mental health issues because it provided comprehensive care that assisted in keeping patients/clients in their home community. Drawbacks were that interprofessional collaboration can be time consuming and it is difficult to maintain patient/client confidentiality in a small community. Factors that helped enable interprofessional collaboration included familiarity and trust, physical proximity, being located in a rural community, and professionals' strong connections and commitment to the community while challenges to treating mental health included a lack of facilities, programs, and human resources, as well as high workload among professionals.

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## CHAPTER 1

### Introduction

Interprofessional collaboration has been shown to improve health outcomes for patients/clients as well as to enhance professional satisfaction (D'Amour et al., 2005; Henneman et al., 1995; Baggs & Schmitt, 1997). Little is known, however, about how interprofessional collaboration may function to treat mental health in rural regions. Hutten-Czapski (2001) noted that a major problem in rural health care delivery is a shortage of health care professionals. Rural health professionals often experience high turnover rates, elevated feelings of burnout and isolation, and feelings of minimal social support (Hutten-Czapski, 2001; Kee, Johnson & Hunt, 2002; Sutton & Patterson, 2002). Health care services have become increasingly centralized in urban areas and rural Canadians are forced to travel farther in order to receive care. Thus, rural areas must find efficient and effective mechanisms to provide services (Hutten-Czapski, 2001). Interprofessional collaboration may offer a means of addressing the challenges faced by rural communities because this practice of working together may increase professional satisfaction and reduce feelings of isolation and burnout. This thesis research project had two foci, first, to examine perceptions of interprofessional collaboration among health care professionals working in a rural area, and second, to explore the factors associated with treating mental health in a rural community. Participants consisted of professionals who were working in a rural Newfoundland community and who had completed the Rural Mental Health Interprofessional Training Program.

This chapter provides a review of the literature on interprofessional collaboration and rural mental health. The benefits of interprofessional collaboration for patients

receiving this form of care as well as for professionals are offered. A discussion of the research that has analyzed barriers and facilitators of working across disciplines is provided. Difficulties encountered when treating mental health in rural areas are explored and how interprofessional collaboration can potentially help address these challenges is examined.

## Literature Review

### *Interprofessional Collaboration*

Various definitions of interprofessional collaboration have been proposed (D'Amour, Ferrada-Videla, Martin-Rodriguez, Beaulieu, 2005; Henneman, Lee, Cohen, 1995; D'Amour, Beaulieu, Martin-Rodriguez, Beaulieu., 2004). For the purposes of this research, interprofessional collaboration has been defined as a group of professionals representing distinct disciplines with different values, experiences, and identities who work together as a team to provide health care service delivery. Canadian researchers D'Amour and colleagues (2005) defined the term collaboration as “conveying the idea of sharing and implies collective action oriented toward a common goal, in a spirit of harmony and trust, particularly in the context of health professionals” (D'Amour et al., 2005, p. 116). This definition has been adopted as the working definition for this thesis because it focuses on the interactions and dynamics between health professionals and it describes action toward a common goal, which in this thesis is the treatment of mental health in a rural region.

### *Contexts of interprofessional collaborative practice*

Interprofessional collaborative practices have been incorporated into a variety of work contexts. In school settings, interprofessional collaboration has been instituted in

school-based integrated service delivery teams where a group of professionals come together to make decisions for the student (Anderson-Butcher & Ashton, 2004). These teams typically consist of teachers, school administration, guidance counsellors, school psychologists, and parents. The goals of this practice are to encourage cooperation, communication, and understanding among schools, professionals, participating agencies, students, and their families to “improve the health, safety, education, and economic well-being of children and families” (Anderson-Butcher & Ashton, 2004, p. 43).

Interprofessional collaborative practices have also been implemented in the health care system. Primary health care has been proposed as an approach to improve the traditional health care system (Heath Canada, 2004). Nurses, family physicians, and other allied health professions have been encouraged to work together to provide better health care and access to services, more efficient use of resources, and improved satisfaction for both patients and providers (Enhancing Interdisciplinary Collaboration in Primary Health Care, 2005). It has been hypothesized that primary health care models increase multidisciplinary collaborative practices among professionals working in the Canadian health care system (Heath Canada, 2004). Canadian researchers Sicotte and colleagues (2002) noted that the main characteristics of primary care models are “increased responsiveness of services to population needs and between service integration and co-ordination” (Sicotte, D’Amour, & Moreault, 2002, p. 991).

#### *Multidisciplinary teams*

Interprofessional collaboration has often occurred within the context of multidisciplinary teams (Jones, 2006; Cashman, Reidy, Cody, & Lemay, 2004; Dieleman, et al. 2004; Hall, 2005; Thylefors, Persson, & Hellstrom, 2005; Walker, 2003). In his

review of the literature on interprofessional collaborative work, Walker (2003) evaluated the outcomes associated with using a team-based approach to treat mental health. Team members had three different backgrounds: health, education, and social work. Walker (2003) found that team members enjoyed working in a positive multidisciplinary environment, where ideas were shared, exchanged, and discussed. A positive culture for teamwork was characterized as a flexible, reflective atmosphere, open to change, and new ideas that optimized professional judgment. As a result of working in teams, professionals reported increased understanding of other disciplines and more opportunities to share skills and resources (Walker, 2003).

Cashman and colleagues (2004) surveyed a group of physicians and nurses working on a multidisciplinary team in a primary health care setting in the United States. Researchers were interested in identifying factors that contribute to and inhibit team effectiveness. Facilitators included: constructive criticism among professionals, assertiveness, effective communication, and understanding of personality styles. Barriers found were: heterogeneity of team composition, work overload, and role conflict (Cashman et al., 2004).

Canadian researchers Dieleman and colleagues (2004) examined perceptions of health care professionals including pharmacists, physicians, and nurses working in community-based teams. They found collaborating in multidisciplinary teams was most effective when dealing with complex cases and when being a team member provided opportunities to support one another while reducing feelings of professional isolation. Members of successful multidisciplinary teams who engaged in work-place interprofessional collaborative activities perceived their experiences as highly rewarding

and satisfying (Dieleman et al., 2004).

### *Theoretical framework*

Numerous theoretical frameworks, such as organizational theory, social exchange theory, a model of team effectiveness, organizational sociology, and an interdisciplinary alliance model have been proposed to capture the dynamics of interprofessional collaboration (D'Amour et al., 2005). Organizational theory has been adopted as the theoretical framework for this thesis because it captures the complexity of the process. According to organizational theory, interprofessional collaboration can be understood to occur on three levels: the interactional level (interpersonal relationships among health care professionals), the organizational level (organizational factors e.g. managerial leadership), and the systemic level (conditions outside the organization e.g. incentives or reimbursement for participating in interprofessional collaboration) (D'Amour, et al., 2004). The Interdisciplinary Education for Collaborative Patient-Centred Practice (IECPCP, 2004) report included findings of a literature review that examined interprofessional education and collaborative practice initiatives within health care settings across Canada (Health Canada, 2004). This report highlighted these three levels (interactional, organizational, and systemic) as the three main determinants implicated in interprofessional collaborative practice. Interactional, organizational, and systemic level determinants have been consistently identified in the literature, although the research on enablers and barriers to collaboration has focused most extensively on the interactional level factors (Health Canada, 2004).

### *Benefits of Interprofessional Collaboration*

Both patients/clients and professionals appear to benefit from interprofessional collaboration (Oandasan & Reeves, 2005; Zwarenstein, Reeves & Perrier, 2005; D'Amour et al., 2005; McNair, Brown & Sims, 2001; Baggs & Schmitt, 1997; Zwarenstein & Bryant, 2000; Henneman et al., 1995). The benefits for these two groups are discussed below.

#### *For patients/clients*

Zwarenstein and colleagues (2005) reviewed the literature on the effects of interprofessional collaborative interventions on patients. This review focused on both pre-licensure interprofessional education interventions and post-licensure collaboration interventions. It found positive effects for the delivery of care (Zwarenstein et al., 2005). Professional groups represented in the studies reviewed included physicians, pharmacists, nurses, laypersons, and the patients themselves. Fourteen studies were included in this review and five of them showed “statistically significant and clinically important outcome differences in patient mortality rates” (Zwarenstein et al., 2005, p.154). Post-licensure collaboration interventions, defined as qualified members of two or more professionals interacting to improve the delivery of care to patients, were effective for specific patient/client populations including geriatric evaluation and management, congestive heart failure, and neonatal care and screening. Patient groups that benefited from this form of interprofessional care ranged from young children to elderly populations.

Health status outcomes, disease incidence rates, mortality rates, readmission rates, adherence rates, costs, and patient or family satisfaction have been examined as potential

gains for patients/clients receiving interprofessional collaborative care (Zwarenstein & Bryant, 2000). In a Cochrane Collaboration systematic review to assess nurse-doctor collaboration, Zwarenstein and Bryant reviewed a number of interventions that were designed solely to promote and improve collaborative practices between nurses and doctors. Examples of interventions consisted of training workshops in collaboration and communication skills, team building workshops, or collaborative meetings. A total of 31 studies were included in the review. Findings were that increased collaboration between nurses and doctors improved patient care, reduced costs, and improved staff satisfaction. It was hypothesized that improved patient care may be the result of increased joint decision-making and communication among staff members.

*For professionals*

D'Amour and colleagues (2005) reviewed the interprofessional collaboration literature in order to identify a conceptual framework for understanding this practice. In doing so, they found heightened job satisfaction and reduced turnover among professionals who worked collaboratively. Increased coordination and shared responsibilities were other outcomes of interprofessional collaboration (D'Amour et al., 2005). Similarly, a report developed through the Enhancing Interdisciplinary Collaboration in Primary Health Care initiative examined the factors that facilitated collaboration at the individual level (Individual Providers and Health Care Organizations in Canada, 2005). The report identified that collaborative practices led to increased work satisfaction among professionals.

The most common outcome reported was increased job satisfaction (Henneman et al., 1995; Baggs & Schmitt, 1997). Other outcomes included a better work environment,

such as support, nurturing, cohesiveness (Henneman et al., 1995), pleasant work environment (Baggs & Schmitt, 1997). Baggs and Schmitt (1997) found that time savings, improved decision-making, and learning from each other was the result of having an opportunity to gather information from various perspectives while working across professions.

### *Facilitators to Interprofessional Collaboration*

A number of studies have attempted to identify the facilitators of interprofessional collaboration (Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005; Hacker & Wessel, 1998; Oandasan & Reeves, 2005; Janssen et al., 2004; Russell & Hymans, 1999; Barker, Bosco, & Oandasan, 2005; Liedtka & Whitten, 1998). They will be described according to the three levels of organizational theory: interactional, organizational, and systemic. The interactional level targets interpersonal relationships between health care professionals, the organizational level focuses on factors within the organization, and the systemic level includes conditions outside the organization (D'Amour et al., 2004).

#### *Interactional level*

Important interactional level enablers to collaboration have been identified including trust, a willingness to collaborate, effective communication, and mutual respect (Martin-Rodriguez et al., 2005; Henneman et al., 1995). Research has been done mostly with health professionals working within a health setting. For example, Martin-Rodriguez and colleagues (2005) reviewed the empirical literature from 1980 to 2003 and identified enablers to interprofessional collaboration. The majority of the research focused on the interpersonal relationships among professionals as contributors to

successful collaborative practices. In addition to the facilitators mentioned, they found that a clear definition and understanding of professional roles was also important (Martin-Rodriguez et al., 2005). Hacker and Wessel (1998) reviewed the literature on the collaborative practices between school-based health centre professionals and school nurses who worked in the education system. Clarification of roles, leadership, coordination, and creativity were identified as important for effective collaborative practice in the school context.

#### *Organizational level*

Although a number of factors have been proposed as facilitators of interprofessional collaboration at the organizational level, to date there is no supporting empirical evidence. Managerial leadership and expertise, “champions” (defined as well-established individuals holding positions of leadership within the organization), availability of qualified managers, the training of service providers, and access to funding and resources have been identified in the literature as potential organizational level facilitators (Martin-Rodriguez et al., 2005; Barker et al., 2005). Champions maintained the role of effective communicator or convincer and were skilled at contacting and engaging the support of important stakeholders and key partners (Barker et al., 2005). Henneman and colleagues (1995) have also suggested that an organization’s philosophy must support interprofessional collaboration by valuing participation, fairness, and freedom of expression.

#### *Systemic level*

Systemic factors that appear to impact interprofessional collaboration included compensation for time devoted to interprofessional collaborative practice, clear policies

governing professional practice, and a system of measurement (Martin-Rodriguez et al., 2005; Liedtka & Whitten, 1998). Providing incentives and compensation to engage in interprofessional collaborative practice have been suggested as enablers to teamwork. Interprofessional education activities that allow different professionals an opportunity to meet and exchange ideas with each other has also been proposed as a systemic facilitator. The Center for the Advancement of Interprofessional Education (CAIPE; 2002) has defined interprofessional education as “occurring when two or more professions learn with, from and about each other to improve collaboration and the quality of care.” In Canada, a number of interprofessional education initiatives are currently being implemented and assessed across the country through Health Canada’s Interdisciplinary Education for Collaborative Patient-Centred Practice (IECPCP) initiative (Health Canada, 2004). It has hypothesized that these will result in increased interprofessional collaborative practice, although to date there has been no empirical evidence to support this claim.

### *Barriers to Interprofessional Collaboration*

Interprofessional collaboration has often been difficult to implement because it is challenging to coordinate health care service delivery among diverse groups of professionals. In order to understand obstacles to interprofessional collaboration, a number of studies have examined barriers (Darlington, Feeney, & Rixon, 2005; Oandasan & Reeves, 2005; Janssen et al., 2004; Barker et al., 2005; Liedtka & Whitten, 1998; Sicotte et al., 2002; Reese & Sontag, 2001).

*Interactional level*

Unrealistic expectations about other disciplines, professional knowledge boundaries, professional culture differences, and a lack of knowledge about other professions' expertise, skills, training, and theory have been identified as challenges to teamwork (Darlington et al., 2005; Barker et al., 2005; Reese & Sontag, 2001; Liedtka & Whitten, 1998). Barker and colleagues (2005) found that individual professional disciplines were often reluctant to reach out and join other professional groups. Disciplines became protective of their own territorial turf and only engaged in interactions with members of their own disciplines.

Sicotte and his colleagues (2002) also reviewed factors that inhibited interdisciplinary collaboration. The major difficulties identified to interprofessional collaboration were related to group dynamics and included conflicting values and beliefs, interpersonal incompatibilities, tension, animosity, annoyance, and disagreement among team members. The contextual factors had less of an impact on the success of the interprofessional collaborative practices (Sicotte et al., 2002).

*Organizational level*

Differing theoretical bases, values, and mandates of various organizations, as well as inadequate resources and information were found to create challenges to working collaboratively at the organizational level (Salmon, 2004; Darlington et al., 2005). Janssen and colleagues (2004) conceptualized implementing collaborative practice as an innovation. Innovations were viewed as the introduction of something new, which in a group setting can lead to increased workload for group members. As such, the implementation of interprofessional collaborative activities created additional

responsibilities for professionals (Janssen et al., 2004), which may be associated with lower levels of satisfaction and well-being among team members.

*Systemic level*

Systemic level factors are determinants outside of the organization such as social, government, or educational systems (D'Amour et al., 2004). While the empirical evidence is lacking in this area, Henneman and colleagues (1995) hypothesized that issues surrounding working in teams may be explained by social factors. Power differences created by stereotypes or differences in social backgrounds can create barriers to working interprofessionally (Henneman et al., 2005). This could result in hierarchical relationships among professionals, which would generate inequality and create difficulties when collaborating.

Without government support, financial incentives, or interprofessional education training opportunities, collaborative practice may be inhibited (Oandasan & Reeves, 2005; Sicotte et al., 2002). While interprofessional collaboration has been shown to offer benefits for professionals, often this practice involves a time commitment (e.g. attending meetings, participating in training, and coordinating schedules). Thus, having external support in the form of money, resources or extra time from a governing body may make it more attractive.

As noted earlier, interprofessional education has been hypothesized to facilitate collaboration; conversely, a lack of interprofessional educational training opportunities has also been viewed as a potential systemic level barrier. Many students are taught within unidisciplinary clinical models, which focus on skill development within individual disciplines and does not foster an understanding or knowledge of other

disciplines (Sicotte et al., 2002). Students develop their own specific set of competencies, attitudes and knowledge, and as professionals, they may have difficulties collaborating, relating and working with other disciplines (Sicotte et al., 2002).

### *Collaborative Mental Health Practice in Rural Settings*

#### *Rural mental health*

A second purpose of this thesis research was to understand some of the issues associated with treating mental health in a rural environment. Health Canada (2004) has defined mental health as:

The capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality (p. 7).

This definition of mental health was adopted as the working definition in this thesis because it considers the influences of the individual, the group, and the environment on mental health, recognizes the cognitive, affective, and relational aspects of mental health, and acknowledges the interaction between these processes and mental health.

Hutten-Czapski (2001) noted that while there are many challenges associated with healthcare across Canada, these problems are exacerbated in rural and remote areas of the country. One of the main difficulties faced in rural areas when providing health care delivery is the persistent shortage of health care professionals (Hutten-Czapski, 2001). The Canadian Institutes of Health Information (CIHI; 2006) recently released a report comparing the health status in rural populations to urban ones in Canada. Compared to urban populations, rural Canadians reported lower socio-economic conditions, lower educational attainment, showed less healthy behaviours, and had higher mortality rates.

Individuals living in rural areas typically had to travel longer distances and on more dangerous roads so that injuries and death due to traffic accidents were higher among these Canadians.

In order to gain insight into rural life, Thorngren (2003) conducted a focus group with 12 individuals living in rural United States. Participants were asked to define rural life, share their perceptions of mental illness, and discuss ways in which rural life has affected their mental health. They identified a connection with the land, a life revolving around chores, the crops and continuous work, as well as the ability to work hard as characteristics unique to rural life. They also stated that there was a stigma associated with seeking treatment for mental health problems in rural communities. Findings from this research offer some insight into perceptions of rural mental health, although it is important to recognize the limitations of this research, since a small and homogeneous group participated in the study.

#### *Rural mental health practice*

The practice of treating mental health in a rural area differs from that in an urban setting. Unique features of a rural area created obstacles to treating mental health, including geographical and transportation issues, minimal availability of services, limited access to providers, and increased stress on providers (Thorngren, 2003; Barbopoulos & Clark, 2003). Other difficulties related to rural culture included low levels of aspiration, reliance on agriculture and fishing as a primary source of income, resistance to new ideas, and a tendency to view social problems as exterior to the quiet town (Thorngren, 2003; Barbopoulos & Clark, 2003). Difficulties maintaining confidentiality and anonymity

have also been found to be a challenge to treating mental health in a rural area (Barbopoulos & Clark; NARMH, 2000; Thorngren, 2003).

Typically in rural areas with few or no psychologists, an individual's primary entry to the mental health care system is through the primary care physician. Zvolensky and colleagues (1999) examined the communication gap that existed between clinical psychologists and primary care physicians. While mental health problems have often been expressed to primary care physicians, this can be problematic, since primary care physicians frequently do not have formal training to deal with psychological concerns. Additionally, due to time constraints, primary care physicians do not have time to complete comprehensive assessments and treatment of mental health conditions (Zvolensky, Eifert, Larkin & Ludwig, 1999).

Kee and colleagues (2002) examined rates of burnout and social support among 220 mental health counselors working in a rural area of the United States. Findings indicated that 55% of the sample scored at the moderate or greater level in burnout and 76% scored below the average range for social support. An inverse relationship was found between burnout and social support. A similar finding was reported among professionals who participated in the National Association for Rural Mental Health's (NARMH, 2000) research. Professional isolation, minimal support, high feelings of burnout, and turnover rates created job dissatisfaction, which negatively impacted the recruitment and retention of new professionals to rural areas. These factors made the referral and consultation process challenging (NARMH, 2000).

*Interprofessional collaboration and rural mental health practice*

Craven and Bland (2006) conducted a systematic review of the interprofessional collaboration literature in order to identify better practices in the treatment of mental health care. Findings indicated that collaborative practice may lead to positive outcomes in the treatment of depression (Craven & Bland, 2006). All of the studies included in this review were conducted in urban settings because little research has examined the practice of working in teams to treat mental health in rural areas.

Collaboration has been suggested as a means of treating mental health issues in rural areas; however, difficulties have arisen in practice (Smith, 2003). In the pilot sites of the Rural Mental Health Interprofessional Training Program, Cornish and colleagues (2003) noted that interprofessional collaboration in rural areas is different than urban settings due to professional isolation, smaller numbers of practitioners, and broader service demands placed on professionals. Professionals who participated in the training program showed improved collaborative practice and increased awareness of the roles and responsibilities of other disciplines (Cornish et al., 2003). One consistent challenge reported by participants was the lack of physician participation in interprofessional collaborative training activities (Cornish et al., 2003; McVicar et al., 2005). Non-attendance by the physicians has been interpreted by other professionals as an unwillingness to participate and may create challenges when working interprofessionally.

Given the issues surrounding the provision of mental health care in rural regions, it has been hypothesized that interprofessional collaborative practice may address some of these difficulties. Working collaboratively across disciplines may help increase perceived levels of support, potentially reduce feelings of isolation and burnout, as well

as increase job satisfaction, which in turn may reduce turnover rates. Working in teams may also create increased opportunities for consultation and referrals among professionals.

While interprofessional collaboration has been shown to improve health care service delivery and increase professionals' satisfaction, very little is known about the impact of this practice on rural mental health. Many factors have been identified in the literature as potential enablers and obstacles to interprofessional collaboration in rural communities, yet little research has directly examined these facilitators and barriers. This research contributes to this field by examining perceptions of collaborative practice and mental health among health care professionals working in a rural area.

## CHAPTER II

### Methodology

The current study was conducted to examine health care professionals' perceptions of interprofessional collaboration and to explore issues regarding treating mental health in rural areas. Participants described their understanding of interprofessional collaboration, the advantages and disadvantages to this form of practice, what they perceived as the facilitators and barriers to working in teams, and the challenges associated with treating mental health in a rural area. The methodology for this study is outlined in this chapter including the characteristics of the participants, a description of the interview questions, data collection procedures, and data analysis.

#### *Background to Study*

All participants had been part of the Rural Mental Health Interprofessional Training Program (RMHITP). This program was a component of a larger research project, Interprofessional Education Strategy for Newfoundland and Labrador, one of eleven projects funded by Health Canada in 2005 (Curran, Cornish, Church, Callanan, & Bethune, 2005). The larger project was initiated at Memorial University in Saint John's, Newfoundland and involved collaboration among the Faculties of Medicine and Education, the Schools of Social Work, Nursing, and Pharmacy as well as the Counselling Centre (Curran, et al., 2005). The intention of the larger project was to examine the impact of interprofessional education activities on interprofessional collaborative practices among professionals working in Newfoundland and Labrador (Curran et al., 2005). The research design was a Staged Innovation approach that made use of experimental and control-replication groups and allows the posttests of

experimental groups to be compared with both the pretest and posttest scores of control-replications (Curran et al., 2005).

This program focused on the development of interprofessional collaborative practice in six domains of mental health practice. Training modules included: interprofessional collaborative practice in mental health, building and maintaining productive relationships with patients, using Stages of Change theory and Motivational Interviewing to treat substance abuse, using Solution-Focused therapy to work with adolescents and their families, using Cognitive-Behavioural Therapy to treat anxiety and depression, and developing interprofessional Assertive Community Treatment, and crisis management (Curran et al., 2005). The six education modules were delivered and evaluated in six rural communities of Newfoundland and Labrador. Participants completed three different questionnaires. An “Attitudes Toward Interprofessional Interdisciplinary Health Care Team Survey” and a “Teams Skills Scale” were used to measure attitudes and perceptions of confidence regarding interprofessional collaboration. A “Consultation and Training in Mental Health Needs Survey” was also completed to evaluate changes in professional practice as a result of participation in the program (Curran et al., 2005).

The first two modules were delivered on site with professionals working in the rural community using a face-to-face workshop format and the remaining four modules were offered through videoconference sessions held every two weeks over a period of 40 weeks. Each module was delivered using a similar format: participants were introduced to the content of each topic area, then they broke into small groups to practice the skills and work through cases, and finally they were encouraged to share cases with the entire

group. The rationale for this format was that participants would develop new skills and begin to work collaboratively and interactively with their peers.

### *Participants*

Participants in the current study were 12 professionals who had completed the Rural Mental Health Interprofessional Training Program (RMHITP). Purposive sampling was done. The three selection criteria were: participation in the RMHITP, regular attendance at sessions, and creating a representative sample of the professions that participated in the training. Professionals that participated in the RMHITP included: one youth worker, five nurses, six social workers, two nurse practitioners, one recreational therapist, two guidance counsellors, one occupational therapist, one family physician, two police officers, one dietician, and one mental health counsellor. In order to ensure a heterogeneous sample of professionals, attendance lists were examined to confirm that the sample for this study represented all of the professions that participated in the training program.

### *Research Design*

A qualitative methodology was chosen for this thesis because it complemented the quantitative data collected through questionnaires and surveys administered as part of the RMHITP project. A phenomenological approach was adopted for this research. McCaslin and Scott (2003) stated that “phenomenology is described as the study of shared meaning of experience of a phenomenon for several individuals” (p. 449). Using this approach, the researcher synthesizes the interview data in order to describe a shared experience of the participants, which creates a central meaning to the interviews

(McCaslin & Scott, 2003). In this thesis, the essence of the interview data was participants' perceptions of interprofessional collaboration and rural mental health.

In a phenomenological approach, researchers need to consider how their experiences, values, biases, and expectations may influence them throughout the research process. In this case, the researcher grew up in a rural community and had experience working collaboratively in a school setting. From these experiences, the researcher had gained an awareness of the challenges associated with service delivery in a rural setting, the lack of resources in a small community, and an appreciation for the stigma associated with mental illness in a rural community.

Second, qualitative methodology suited the goals of the research, which were to assess participants' perceptions of collaborative practice and rural mental health care. Berg (2004) noted that qualitative research "seeks answers to questions by examining various social settings and the individuals who inhabit these settings" (p. 7). Visiting professionals in their natural environment (health care settings) allowed for observing any social interactions or human dynamics that were influencing interprofessional collaborative practices. As noted in the literature, the interactional level determinants impacting interprofessional collaboration have been most heavily researched and are considered most influential.

Third, qualitative methodology has been considered the desired approach when interested in understanding the meaning individuals assign to their experiences. The experiences of individuals have been found to be impacted by emotions, motivations, and characteristics within the individual (Berg, 2004). Morse (2006) stated that qualitative methodology was useful when examining participants' perceptions of an event and/or

issue because it provides “insight, which is crucial to understanding what is going on, for seeing the implicit, for uncovering, for interpretation and for developing strong concepts and theories” (p. 3). This fits with the goals of this research which were to understand and explore participants’ perceptions, experiences, and insights into interprofessional collaboration and rural mental health care.

Finally, as noted in the literature, little research has been conducted examining the practice of working in teams in rural areas. Given the unique features of rural life, it has been proposed that the practice of interprofessional collaboration differs in rural areas as compared to urban settings. For these reasons, this thesis research can be considered exploratory, that is investigating an emergent field. Marshall and Rossman (1995) stated that qualitative interviews are appropriate when investigating a phenomenon that is not well understood in order to generate hypotheses and directions for future research.

Interviewing was used to understand how a cross section of individuals representing a variety of disciplines who treat mental health perceive working collaboratively in teams. Participants were interviewed independently in order to capture potential discipline differences about their views of interprofessional collaboration or rural mental health care. Interviews provided detailed rich data from health care professionals about their perceptions, experiences, and first-hand subjective interpretation of interprofessional collaboration to treat mental health in a rural area.

Interview questions (see Appendix A) were developed based on literature about interprofessional collaboration and teamwork as well as questions used in two pilot projects carried out in two rural Newfoundland communities (Cornish et al., 2003; McVicar et al., 2005). Questions one through three gathered demographic information

regarding the professional's discipline and how long he or she had been working within the profession. Questions four and six asked professionals about their experiences and perceptions of challenges to treating mental health in a rural community, while Question five focused on professionals' understanding of what worked best. Questions seven, eight, and nine were adapted from the pilot projects (Cornish et al., 2003; McVicar et al., 2005). They asked professionals to reflect on their understanding of interprofessional collaboration, their likelihood of engaging in this form of practice before and after training, and to provide examples of their experiences collaborating. Questions 10 through 14 were based on issues identified in the literature on interprofessional collaboration. Question 15 was adopted from the pilot project questions and asked participants about the impact of the training program on their practice. Questions 16 and 17 encouraged professionals to describe the enablers and obstacles to interprofessional collaboration in rural communities. In order to determine if professionals recognized the facilitators and barriers discussed in the literature as characteristic of their community, participants were queried appropriately when necessary. Finally, in Question 18, participants reflected on their experiences with the RMHITP project and shared their views on interprofessional collaboration and whether this practice was useful for treating mental health. The 18 questions were piloted with a family physician working in a rural community of Newfoundland. Based on this initial interview, one question was re-written for clarity.

### *Procedure*

Participants were interviewed seven weeks after completing the six modules of training. It was thought that this time period would give sufficient time for them to be

able to reflect on their experiences and involvement in the training program. Participants were identified and contacted by the Primary Health Care Coordinator in the community and interviews were arranged in advance. Face-to-face structured interviews were conducted with all participants. All professionals were interviewed individually, with the exception of two participants who wished to be interviewed together. Interviews ranged from 20 to 60 minutes in length. The researcher carried out all interviews, which were then audiotaped and transcribed, and all identifying details removed. Only the researcher and the thesis supervisor (Dr. Elizabeth Church) had access to the data. Preliminary findings were shared with all participants via email. This was done to ensure that their perspectives were represented accurately. Only two professionals responded: one participant made a minor wording change and the other respondent did not make any edits or changes.

### *Data Analysis*

The interviews were analyzed primarily through thematic analysis because it corresponded to the goals of the research, which were to understand health care professionals' perceptions of interprofessional collaboration and rural mental health care practices. This approach to data analysis has also been associated most commonly with phenomenology (DeSantis & Ugarriza, 2000). As noted by DeSantis and Ugarriza (2000): "In phenomenology, words, phrases, and sentences abstracted from an interview are labelled as themes. The themes are then grouped into what are called theme clusters, themes, categories and essences" (p. 358). DeSantis and Ugarriza (2000) defined theme:

A theme is an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole (p. 362).

Braun and Clark (2006) defined thematic analysis as a “method for identifying, analysing and reporting patterns or themes within data” (p. 79). Large data sets are re-organized into manageable patterns of results. Thus, themes emerge from the data and are categorized in order to facilitate the presentation of results (Braun & Clark, 2006).

Aronson (1994) noted that thematic analysis focused on the identifiable themes and patterns in the transcriptions. As a next step, findings are generated based on themes and the corresponding body of empirical literature (Aronson, 1994). While theme generation is influenced by the researcher’s theoretical orientation and understanding of the literature, themes are identified mainly based on information from the transcripts. Having an understanding of the literature has been considered advantageous and can serve as a means of comparing the emerging themes from the text with the empirical research findings (Morse, 2000).

The interview transcripts were initially read a number of times. A list of all the responses to the questions asked in the interviews was developed by the researcher. From this list, categories were developed within each question. This list of general categories was analyzed and repeated responses were grouped together, initially question by question. Next, categories were examined across questions in order to look for overarching themes or patterns across questions. As a final step, categories were re-organized into overall themes and subthemes.

The main theme was determined based on the following criteria: the majority of participants discussed it, the participants referred to it frequently through the interviews, and it linked many important comments from the participants. For these reasons, the main theme can be considered an overarching theme. Sub-themes were identified in a

way that provided support to the overall theme. A sub-theme was considered more influential if it was endorsed by a greater number of participants. For example, if eight participants identified a particular theme, it was considered more important than a theme that was mentioned only by four participants. In the results section, individual sub-themes are arranged in order of importance.

## CHAPTER III

### Results

This chapter describes participants' understanding of interprofessional collaboration, lists elements of this type of practice, and gives examples of their experiences with collaboration. Additionally, this section will provide a discussion of participants' perceptions of the advantages and benefits to working in teams, the drawbacks to collaboration, and facilitators to this type of practice. Finally, participants' perceptions of specific challenges to treating mental health and the impact of the Rural Mental Health Interprofessional Training Program (RMHITP) are offered.

#### *Participants*

A total of 12 professionals participated in the interviews. All worked in the rural community and had participated in the RMHITP project. Except for two individuals who requested to be interviewed together, all other participants were interviewed individually. Professionals from nine professions participated: guidance counsellor, youth worker, social worker, police officer, physician, community health nurse, mental health counsellor, occupational therapist, and nurse practitioner. Participants worked in four different systems: health (seven professionals), education (one professional), justice (two professionals), and community (two professionals). Even though participants worked in a variety of systems, all considered themselves health care professionals. Since there are certain professions represented by only one person, individual professionals will not be identified in order to ensure anonymity. The health system comprised those professionals who worked in the hospital: nurses, physician, mental health counsellor, occupational therapist, and social worker. The education system consisted of a professional who

worked as a guidance counsellor in the school system. The two professionals who worked in the justice system were a police officer and a social worker. Finally, two participants worked in the community as a social worker and a youth worker.

Eight of the twelve respondents had over 10 years of experience in their professional role, two had seven years of experience, and the other two had four years experience. Almost all (11 out of 12) were female. Five of the participants had worked in the community for over ten years, three professionals had worked in the community between five and nine years, and four participants had worked in the area for less than five years. Most (ten) of the participants had also worked in an urban setting at some point in their careers, while the other two participants indicated that they had lived in urban areas during their training. Ten of the participants were originally from the area or surrounding area and two were from urban locations, one in Newfoundland and one in Nova Scotia. All participants had to leave their home community in order to receive education and training in their professional roles.

Participants were involved in mental health activities in a variety of ways. Five professionals perceived their role as direct service provider. This included diagnosing mental illnesses, doing intakes for Mental Health Services, dealing with mental health issues in youth, and conducting psychotherapy with clients. Two other participants described having limited or indirect involvement in mental health care in their community because their patient/client populations did not have a primary diagnosis of mental illness. For instance, one participant stated that:

I generally don't have any direct involvement per se. I do have, in terms of dealing with changes in their life. Some post-stroke, dealing with the changes. So there is to a certain extent there. So it's not directly obvious but there are always mental health issues you are dealing with in terms of life changes.

Three other professionals saw their connection with mental health care as secondary to physical illness. For example, one participant indicated that:

My client group right now for the past year and a half are persons with disabilities, physical or developmental, adults and children. And sometimes there are dual diagnosis of mental health. So some of my clients would have a diagnosed mental illness as well.

Three others took part in committee work that focused on mental health issues. An example was the Peaceful Communities Initiative, which was an interdisciplinary working group that targeted youth issues including mental health.

#### *Committed to Collaboration*

All of the participants strongly endorsed the value of interprofessional collaboration to treat mental health in a rural community. There was a lot of unanimity across participants' responses. Even though participants represented nine different professions and worked in a variety of systems, all were strong proponents of collaborative practice. Differences in perspective among the professional groups were minimal.

When describing the practice of interprofessional collaboration, participants used language such as "absolutely critical," "necessary," "extremely important," and "essential." One participant explained that interprofessional collaboration "is really important, especially in a rural area." Another participant noted that: "it's absolutely crucial." Overall, participants were committed to the practice of collaborating and working in teams. They also believed that collaborative practice worked well to treat mental health in a rural community, because it provided multifaceted and comprehensive

care useful in treating the complexity of mental health issues. This will be discussed in more detail later.

### *Participants' Understanding of Interprofessional Collaboration*

Participants were asked to define interprofessional collaboration and to provide examples of their experience with collaborative practice. While most participants described an experience specific to mental health, some provided a more general example of working in teams. The examples they gave included meetings with a variety of professionals or organizations, phone consultations with other professionals, creating goals for patient/client care, and having partnerships with other team members. Participants identified five main elements of interprofessional collaboration: it is goal-oriented, it requires a shared understanding, it involves both formal and informal collaboration, professionals work with a variety of disciplines and/or organizations, and collaboration occurs within and across systems. Each of these elements will be described in more detail below.

#### *Goal-focused*

Eight of the participants, including the guidance counsellor, youth worker, family physician, social worker, occupational therapist, and nurses identified collaboration as action toward a common goal. They made comments like “setting goals and working together to ensure the goals are being achieved,” and “coming together for the same goal which is to enhance the treatment and care of your patient or client.” Participants believed goal orientation was important so that all professionals involved in the care of patients/clients were informed of the treatment plan. For example, one participant from the health system defined collaborative practice as:

Interprofessional collaboration, to me it just means good primary health care. Everybody is involved in the patient's care. It works better when you have a variety of professionals, and we are all working towards the same goal for the patient.

#### *Shared understanding*

Participants believed it was essential that all professionals involved in the care of patients/clients have a common focus and were working together effectively toward the same goals. They often described this shared understanding as cohesiveness among the group. By cohesiveness, they meant that professionals had similar perspectives, had a shared sense of purpose, and maintained a collective identity. One participant described this as:

There's just a cohesiveness here of because everyone is dealing with the same issues. The issues aren't the same as you would be dealing with in another community...there's a cohesiveness of just a shared experience and a shared perspective.

Another professional explained that:

Interprofessional collaboration is a group of professionals from different backgrounds getting together to discuss a specific client, set goals for the specific client and work together to ensure these goals are being achieved, and make sure they are working in a cohesive manner so people aren't going off in completely different directions.

#### *Informal and formal collaboration*

Participants referred to both formal and informal collaborative practice. Instances of formal collaboration included grand rounds or Individual Support Services Plan (ISSP) meetings, while informal collaboration was described as corridor consults, coffee break discussions, or lunch room chatting. Three professionals working in the health system cited grand rounds as an example of collaborative practice. Grand rounds occurred at the hospital on a weekly basis and all the disciplines within the health system attended these

meetings. Participants viewed grand rounds as informative and an opportunity to gain a holistic picture of the patient. This holistic perspective was possible because these meetings were attended by professionals working in many disciplines along the continuum of care. A representative from the health system indicated that:

On an interdisciplinary team, for example, like we have grand rounds where occupational therapy and physiotherapy and patient care coordinators and the out-patient...the acute care coordinator, out-patient and long-term care, everyone sits around a table, physicians and stuff, to discuss a client, we are discussing acute care, and facilitate the transfer from acute care to home and that kind of thing.

A participant working in the education system used the example of an ISSP to explain an experience of collaborating and working in teams.

An ISSP is a group of individuals from different agencies. It's an interagency plan for an individual. So at birth, for example, if a public health nurse does a screening with a child and notices that there's some problem, they might all of a sudden call in a psychologist to consult, and a speech therapist, or a whatever. And so all the people start the team. So that is an ISSP. An ISSP team would meet twice a year. And anybody who is identified as a professional, and the parents consent to it while the child is young and then once the child is able to participate and take over the consent then they would provide that, it continues throughout the child's life right up through.

Participants also described informal instances of collaboration. Examples of informal instances of interprofessional collaboration included: corridor consults, coffee break discussions, or lunch room chatting. One professional working in the education system stated that: "Well, we are very informal with each other because we see each a lot." Another participant working in the community noted that: "There was always a very good comfort level there. There wasn't a matter of everybody sort of having to get to know one another." One participant stated that: "We have things in place so that we do a lot of corridor consultations or chatting over lunch or coffee. We see each other really, really frequently."

*Working with professionals from a variety of disciplines*

Participants also described interprofessional collaboration as working with a cross section of individuals. Half of the participants (youth worker, social worker, physician, nurse, mental health counsellor, and occupational therapist) discussed the importance of working together with representatives from a variety of disciplines. A participant from the community stated that: “Interprofessional collaboration means a cross section of individuals who can come together for a certain cause.” This was seen as important because it brought a range of professionals together who could contribute different skills and expertise to a particular patient/client through collaborating.

*Working with professionals from across systems*

Five professionals (nurse practitioners, physician, police officer, and guidance counsellor) discussed the importance of working together with representatives from other systems because it provides a comprehensive perspective on the client. They thought that professionals working in different systems held diverse views on the components of patient care and that it was important to have all these views included. For example, a professional working in the health system stated that:

Everybody gets a chance to voice their opinion. Some of the other professionals actually see these clients, not even in the hospital setting but in the community. So that is really good and informative. It gives you a broad holistic picture of the patient, not just what you are seeing in the hospital.

Another professional working in the justice system stated that: “So if there is inter-agency collaboration, in the long run, I think it benefits the people who are affected by it, especially within mental health issues which obviously is what we are talking about.” In defining interprofessional collaboration, one participant highlighted the

importance of involving a variety of disciplines working across systems, such as health, justice, and community.

I mean basically it is the way we run business every day for the most part. It's people from all disciplines, not even core medical but other professionals, be it the RCMP or be it the Women's Centre or be it the Clergy or whatever. How you all come together for the same goal, is to enhance the treatment and care of your patient or client, whatever you want to call it. And you work together across sectoral disciplines, multidisciplinary, multisectoral, whatever.

### *Advantages to Collaborative Practice*

Participants identified a number of advantages to interprofessional collaboration, both for them professionally and for their patients/clients. They indicated that collaborative practice fostered feelings of value and respect, enhanced quality of care, increased their feeling of being supported, was advantageous for mental health care, created opportunities for learning, and improved decision-making. Each of these benefits will be described in more detail.

#### *Feeling valued and respected*

Except for one participant, all of the respondents reported feeling appreciated by other professionals. They felt that professional groups in the community valued each other's roles, welcomed each other, and that respect was reciprocated. Examples of this were that other professionals in the community consulted with them, asked their opinions, gave positive feedback, and appreciated their contribution. They also felt that others depended on them and recognized their particular expertise. For example, one participant working in the health system shared that:

I feel quite respected and valued. Actually I feel more respected and valued in a rural setting than I would feel in an urban setting. Like in this setting (rural), there are only four family physicians and two hospital-based physicians. So the thing is I will have a physician calling me directly and asking me my opinion on things. Where as in an urban setting, there's X number of physicians, and no one

knows, and everything is changing. You don't get recognized as much in bigger centres because there's so much more going on. There's so many more people...in this position, which is a lot of the reason why I like the rural type setting, is that I feel I actually have a role, and I feel it is respected.

Another participant representing the health system stated that:

I feel valued and I feel respected actually...so I get phone calls from the guidance counsellor, the women's centre downtown in terms of Child Protection. My co-worker will collaborate with me and say, I really need your thoughts. I really need to bounce something off you. And so that is respect, that is value.

One participant described she felt welcomed from the time she began in her position.

I feel very respected and valued just from the fact that when I came into the position, I think everyone I would ever need to collaborate with either gave me a phone call, an email, or saw me out around and said how good it was to have an extra mental health worker but certainly someone in addictions.

Only one participant felt undervalued in her professional role. She believed that she was occasionally misunderstood by other professionals in the community. She said that she is not consistently invited to attend collaborative meetings due to a perception that her time constraints and high workload would inhibit her attendance.

#### *Enhanced quality of care*

Nine of the participants (nurses, social workers, physician, mental health worker, police officer, youth worker, and guidance counsellor) believed that interprofessional collaboration led to improved quality of care for patients/clients. Participants used phrases such as "better plans for clients," "enhanced and coordinated care," "efficient service," and "timely care" to illustrate benefits of this form of practice. They described a number of ways that patient/client care was improved: increased connections with professionals at different points in time over the course of treatment, integrated form of care that consisted of numerous professionals working in a variety of systems, and comprehensive care that took a holistic view of the patient/client with representation from

disciplines working across the continuum of care. For example, one respondent indicated that: "...having four heads are better than one approach...you know, we all come from different disciplines. Being able to interact and put our thoughts out there." Another participant described interprofessional collaboration as: "providing much better patient care...the client, it is not just one person sometimes that they need, so they could avail of different services at different times, take care of different needs at different times."

Participants believed that patients/clients benefited from receiving care from a group of professionals because it provided increased exposure to a range of professionals with different backgrounds who have different skills sets, expertise, and experiences. They also felt that because interprofessional collaboration involved a variety of disciplines, patients/clients benefited from easier access to a range of professionals and services.

I think the benefits of course would be that they would have the expertise of X plus however more people than just X. Sometimes it wouldn't occur to them to go to another alternative for help. So if you were comfortable with a team, and you could refer to the team or whatever, or any member of the team, the person would get the service. Whereas before, they probably wouldn't.

Another participant indicated that: "So people who are doing this full time would obviously have better knowledge than I would. So just utilizing the expertise of other professionals would be an advantage."

#### *Increased support*

Six participants (guidance counsellor, occupational therapist, mental health counsellor, social worker, and nurse practitioners) felt that working with other professionals led to increased support. This helped reduce stress on professionals. For example, one participant indicated that: "Advantages? Well, there's so many of

them...just in terms of there is more support...so it's going to reduce the stress on different professionals.” Another participant believed that interprofessional collaboration helped to diminish the risk of burnout because professionals supported one another, which in turn reduced stress.

And right from the get go, you work collaboratively or you burn out. So collaboration means doing a good job, checks and balances. Not doing it is a high level stress and a high level burnout. Because I could not be in this town for 6 ½ years without having support. Ultimately, it's my management and my supervisor but beyond that, and the real day to day support comes from a professional at the women's centre because I know I can talk to her and say, “Listen, I had a bad day.”...Necessity dictates that we do collaboration or we burn out, and our clients do not benefit.

#### *Advantages for mental health care*

Five participants (physician, youth worker, guidance counsellor, and social workers) saw teamwork and collaboration as advantageous for treating mental health problems in a rural community because it was goal-oriented, targeted the needs of the patients/clients, and helped keep patients/clients in their home community. A participant working in the community stated that: “I guess making sure that all the persons that are involved with that client are working together to ensure all aspects of their needs are addressed.” Another participant working in the health system responded that:

Working with other professionals...that is the only thing that you have because there are so many services that you wish you had, and so many things that you have refer out for...so anything where you can keep the person functioning to the best of their ability in the community and in their own home, you need to be working with the other professionals to ensure that you are providing some services. And it is a coordinated service. Because in a small community, there's no need for two of three or us to be doing the same thing.

Given that mental health problems are often very complex, participants perceived interprofessional collaboration as a means to offer comprehensive mental health care service delivery. They believed that working in teams meant they could address the

many aspects (financial, home, transportation issues) that contribute to a patient/client's mental health. For example, one participant reported that:

You are involving the other disciplines, you are taking care of the financial needs, you are taking care of any home situation problems, the abuse, the addictions. Just everything...the problem came about from little pieces of other things, and you end up with this major problem like depression. So you've got to fix all the pieces before you can actually fix the depression.

Another respondent commented:

So someone may have a mental illness which is impacting on their life situation. They may not want to think about counselling if they don't have the money to pay for transportation. So there's a lot of pieces where other agencies and other professionals can get involved to help get the person where they need to be for them to be a whole well person.

*Enhanced opportunities for learning*

Four participants working in health and community systems described how interprofessional collaboration facilitated learning in a variety of ways: learning from each other's expertise, expanding their knowledge, and sharing and exchanging information. One professional stated:

So some of the advantages are, like I say, that kind of thing where you've got everyone sitting around a table, and just being able to work together and getting information from other areas and things of what should I do here or what shouldn't I do here.

A professional working in the community noted that: "You know the more you learn the less you know. So any time you can sit around a table and discuss things, you are actually learning something." Furthermore, this information sharing and exchange was viewed as "broadening" their understanding of other professionals' roles, knowledge, and expertise.

You know, if you are collaborating, you are utilizing other disciplines who have different skill levels, different knowledge levels. Just that whole seeking out all

of those people with all of their information, it just broadens your knowledge base.

A participant from the health system commented that participating in collaborative activities has expanded her knowledge by strengthening her competencies.

So in collaborating you learn. And so in collaborating with a dietician, I learn something that next time I might be able to utilize. And that is in a consult with her. So it enhances my skills set.

*Improved decision-making*

Four participants believed that collaborative practice provided opportunities for making connections with other professionals. Professionals turned to each other for advice about their treatment plans. They believed that being able to discuss their ideas with one another was confirming and resulted in making better decisions for their patients/clients.

So even that part of it, even though someone is not here around the table with us, that piece of again the collaboration of having someone that you can look to and say...Look, this is what I am doing. Do you think it is right? What should I do next?

Another professional noted that interprofessional care means “there is less risk of missing something that needs to be addressed,” and that they consulted with other professionals. Participants believed that bringing a group of professionals together was advantageous because each professional could offer additional information from their perspective about the patient/client that would improve decision-making in treatment.

...being able to interact and put our thoughts out there. And checks and balances. You know, this is what we have been doing and it's just not working. If I'm working with Client A, and they are sitting at the table and we are really struggling, and we say let's pull in this one (another professional) and this one, and let's talk about what is going on here. That to me is an advantage.

### *Drawbacks to Collaborative Practice*

Participants also described disadvantages to collaborative practice, both for professionals and for patients/clients. Compared to their comments regarding the advantages, they had a lot less to say. Sometimes it seemed as though they were searching for how to respond. Generally, when they listed disadvantages or drawbacks, they followed them with a caveat. Despite their hesitation, and with prompting from the interviewer, they identified some: time consuming, difficulties maintaining confidentiality and anonymity, as well as pay structure.

#### *Time consuming*

Almost all of the participants (nine out of twelve) including nurses, social workers, occupational therapist, mental health worker, physician, and guidance counsellor reported that collaboration is time consuming. Everyone already had busy schedules and it took time to coordinate and organize meetings, as well as to adjust caseloads to accommodate meetings. For example, one participant from the health system stated that:

I guess the things like if you are going to sit around, trying to get people together and time. Everybody is busy...but I guess like time factors and trying to get a date and time where people can meet if they are going to discuss particular clients and stuff like that always seems to be an issue when you are involved in committees and that kind of stuff. Time management and stuff, really trying to adjust your caseload to accommodate.

Even though professionals mentioned time constraints, the majority of participants stated that while collaborative practice was challenging in the short-term, this was outweighed by the positive benefits over time. A professional working in the education system noted that: "I don't see many disadvantages. I mean it's time consuming but I think the initial amount of time you invest has its own pay-off for down

the road.” Another participant working in the health system described interprofessional collaboration as a more efficient practice that saves time in the long run.

And sometimes you are thinking, “Oh my gosh, not another meeting,” but in the end you are...by having that meeting you are working with these people, you are probably helping 10 clients as opposed to the hour that you took for the meeting and you would have been working with one, an probably you would have been stuck and had to call some of these people anyway.

*Lack of confidentiality and anonymity for patients/clients*

Half of the participants commented that interprofessional collaboration made it difficult to maintain privacy. For instance, a professional working in the justice system stated that: “In small communities everybody knows everybody’s business. People listen to scanners all night long.” The lack of confidentiality was seen as problematic in a rural community because there was a stigma regarding mental health issues. A professional working in the education system indicated that: “Sometimes it is embarrassing for people, you know if everybody knows you...there are stigmas around mental health.” A participant representing the health system reiterated a similar view:

I guess maybe it would be the anonymity piece. Obviously there’s a stigma attached. Lots of times these people just don’t want to tell their story to one person. They certainly don’t want to tell it to five people. Having to see this one and then that one and then this one, I’m sure would be a drawback for a patient.

Participants also commented that the dual relationships between professionals and patients/clients made it difficult to maintain anonymity and confidentiality in a rural community. A dual relationship was understood as a personal and a professional relationship with a patient/client. Working as a professional in a small community, there were increased chances of knowing your patient/client or his or her family member on a personal level.

I guess one of things was sometimes it might be a little bit awkward. Because sometimes you might be dealing with people's family members or friends. Or everybody is a friend or a foe around here, you know. So that might make it a little bit uncomfortable for people.

*Pay structure*

One participant reported that collaborative practice was financially detrimental. She stated that attending meetings and participating in collaborative activities diminished clinical time and as a result she lost money because of fee for service structures.

*What Makes Collaboration Work?*

Participants described a number of facilitators to interprofessional collaboration in their community: connection and commitment to the community, familiarity and trust, physical proximity, rural community, and being recognized as a primary health care site. Each will be explained in more detail below.

*Connection and commitment to community*

As noted earlier, ten of the twelve professionals interviewed were from the local area. One participant noted that: "Most people who live here, grew up or lived the majority of their life here." Another perspective was that: "A lot of our professionals are actually from the community so there is a vested interest." Similarly another respondent stated that:

So you live in the community. You have your family in the community. You work in the community. You want the best for your community. Versus in the large centre, when I worked and lived there, my job was my job, and my home life was my home life.

Being from the area or surrounding areas was seen as creating a commitment to the health and well-being of the people in the community and thus a potential facilitator to collaborative practice. Many professionals raised their families in the community, had

lived in the area for a long time, and felt very much a part of the community. As a professional working in a rural community, public perception was viewed as very influential. Professionals shared that in a small area, professional and private lives are integrated. For instance, one participant stated that:

The same people that you are helping out with things that are going on for them are the same people that you are probably standing behind in the grocery store line. So there's a sense of community...certainly they are part of your community.

Boundaries were also perceived as less rigid in a small community, perhaps because the professionals knew one another on a personal level in addition to a professional level.

I think that in terms of resources, yes, we are limited but we have people here who are truly highly educated and motivated, who really want the best for the community. So you live in the community. You have your family in the community. You work in the community. Versus in a large centre, when I worked and lived there, my job was my job, and my home life was my home life. It's so different. And yes, we need that self-care and we need those boundaries. But the boundaries become a little less rigid and more integrated. And that needs to be. And always professional, obviously. But that sense of this is your life, this is your home, this is your community.

#### *Familiarity and trust*

Eight respondents including nurses, guidance counsellor, social worker, mental health worker, and occupational therapist indicated that familiarity with one another and trust contributed to effective collaboration and working in teams. Many of the professionals had been in their positions for many years and felt that this helped to create an openness and high level of comfort with one another.

And so it is the same with all of the disciplines – we know them but we also respect them because we have known them for a long time. We know how dedicated they are. We know their style of practice and we are happy with that.

Familiarity included both professional and personal aspects. Participants stated that in addition to a strong professional working relationship, they often had personal

connections with other professionals in their community. For example, a participant from the health system indicated that:

I guess maybe that thing of because everybody knows everybody. Like you've got that more sense of trust and that kind of thing, I guess. I don't know, it's kind of like you are working with a physician but at the same time, they might be your own family physician...you've got a professional relationship but maybe some of a personal relationship as well. So the trust issue and everything is there that you need I think it is important in order to work together.

Familiarity also meant having a good understanding of other professionals' roles and their "scope of practice." For example, one participant working in the justice system stated that:

Because we are a small group of people and most of us have been around awhile, we know each other fairly well. We are comfortable in the knowledge of what each individual person can do or what our scope of practice is. So we sort of know the boundaries of what each can do and for who we can refer certain things.

Being knowledgeable about others' expertise led to appropriate referrals among professionals. Additionally, another participant representing the health system stated that: "So we know each other's role and we work well together to best facilitate that client to be independent and able to manage at home and that kind of stuff."

Trust was also viewed as critical for teamwork. Participants felt that positive working relationships among professionals developed over time, which led to feelings of trust toward one another. Also, participants felt that because many of the professionals had worked in the area for a number of years, trust was able to develop.

And you get that build up of trust is the thing I think too. You learn to trust people because you have been around them so long that you know their work ethics and you know their role and stuff.

*Physical proximity*

Six respondents believed that the work setting helped facilitate collaboration. The hospital was in a central location in the community and housed a number of the professionals. Professionals working in the health system saw each other on a regular basis and could easily contact one another:

For here, I guess a lot of disciplines are housed in one building. It's a big plus. It makes it so much easier because you are physically seeing people. You are walking by them, and you know who is who, and you know who is in the building.

The hospital was also perceived as a hub by professionals working outside the health system. For instance, a participant working in the education system stated that:

It's easy to get together because everybody only has a five minute drive. The hospital is really a central location. You know there is a facility where we can all meet.

Physical proximity facilitated interprofessional collaboration because frequently seeing one another increased the chance for both formal and informal collaboration. In a small community, even professionals outside the hospital were only a short distance from the hospital.

*Rural community*

While on the one hand, the smallness of the community was viewed as a barrier to collaborative practice, on the other hand it was also perceived as an enabler. Six professionals (social worker, mental health counsellor, guidance counsellor, nurse practitioners, and occupational therapist) believed that living in a rural area promoted cohesiveness among professionals. Because of a lack of resources in the community, professionals were forced to rely on their co-workers for support and to provide care to

their patients/clients. For example, one participant working in the community shared that:

I think sometimes you are in a rural setting, you are geographically isolated. And you just have to use the services that are present to help your client. And so I think that promotes cohesiveness really. I think you have to reach out to others because you know you can't do it alone. So you have to reach out to other people who have some skills in areas that you don't. The areas that they specialize and are trained in, and get them involved.

A professional working in the health system stated that collaborative practice was a necessity for the community:

I think the necessity. As I said, in a small town, you need it. So if you don't have it, you make sure it happens. I think that in terms of resources, yes, we are limited but we have people here who are truly educated and motivated, who really want the best for the community.

Similarly, another participant working in the health system felt that having few resources in a rural community helped promote teamwork and collaboration. "You've got to be working with the other professionals in order to make it work because of lack of resources." One professional commented:

The advantages are that they are going to get the best care we can provide as a group to them, given the fact that they are in a rural community where there's not a lot of services available. So certainly for them, I am hoping that they are going to see it as being a benefit.

*Primary health care site*

Six of the participants (nurse practitioners, physician, social worker, occupational therapist, and community health nurse) mentioned that their community was chosen as a primary health care site. They considered this recognition an enabler to interprofessional collaboration because it provided funding as well as a structure that facilitated collaborative meetings, created connections among professionals in the community, and initiated teamwork. One participant from the health system stated that:

We have been very fortunate because this site was a primary health care site at the same time I graduated. This community was one of the pilot project sites for primary health care. So we all came together at the same time kind of thing. And so this site has been talking the talk and walking the walk for eight years...and I have been fortunate to be able to work at a site that promotes teams and promotes interdisciplinary collaboration.

### *Barriers to Collaboration*

Participants only identified one barrier to collaboration. Three participants considered a lack of commitment by physicians as a challenge when working in teams. By this they meant that physicians did not participate in collaborative team meetings. This was seen as a barrier to collaborative practice because not all disciplines were represented. One participant who worked in the health system reported that:

I guess I don't see a lot of that territorialism, I suppose. Fear of someone taking over the work that I do and that sort of thing. But again, I don't see a lot of...Maybe sometimes doctors are sometimes harder to draw into that, in terms of actual physical participation. You know, being present. Although I think that has changed too over the years to a certain degree.

Another participant indicated that:

And maybe if there had been more opportunities for physicians to get involved. But some of the teams and stuff that are set up, and all these interdisciplinary works that we are talking about in collaborative practice, be it due to staffing or what mental health workers have seen as confidentiality issues or whatever, they (physicians) have not been at the table.

One professional suggested that high turnover rates might offer an explanation for a lack of physician buy-in.

You may have a lack of professionals. It may be an area where there's a lot of turnover. So if you've got professionals who this is kind of a training site – they come and get some experience but as soon as there's an opening, they are gone – and you have all that turnover. And maybe that could be part of the reasoning for the lack of physician buy-in. Because the hospital turnover rate here, when they were really stuff for staff doctors, the number of locums we had come in was almost like changing rolls of toilet paper. It was weekly.

*Barriers to Treating Mental Health in a Rural Community*

Professionals identified more challenges to rural mental health care than they did to collaborative practice. A lack of human resources, few facilities and programs, and high workload among professionals were considered barriers to treating mental health in their community. Each will be described in detail below.

*Lack of human resources*

Eight of the twelve respondents indicated that there were not enough trained professionals to effectively treat mental health issues. Not only were there few mental health professionals, there were no dedicated resources to coordinate mental health services, and most professionals had minimal training and experience in treating mental health. One participant stated that:

So all of the professions – recruitment and retention of the professionals. We have people that...like we have nurse practitioners and mental health social workers and stuff but there's not enough mental health professionals basically. And even some of the people that are not directly involved with mental health, like they are not a mental health employee...they don't come under the umbrella, like a nurse practitioner, physicians, community health nurses, there's just not enough. And so maybe if there was more of us we wouldn't need to refer to some of the other people.

Another participant noted that:

I guess in an ideal world, if we could have a psychiatrist in our small community. If we could have more self-help groups. If there could be a couple of beds at the hospital that could be used for...and they do use them for mental health for short term. But if you could have someone who could have that kind of opportunity for addictions.

Another barrier was difficulty accessing services. There was no on-site psychologist or psychiatrist in the community so that patients/clients were forced to travel distances to receive specialized services for mental health. Transportation issues,

geography, and weather conditions impacting travel from the rural community were common and often made it complicated to travel to an urban centre.

Our area is very widespread geographically. Our weather is not always conducive to travel, especially in the winter months. So if you give an appointment, and it's hazardous because there's a wind warning or something like that then the client maybe will even sit back longer if they are trying to get to an urban centre to seek mental health services. So transportation issues.

*Lack of facilities and programs*

One challenge was the lack of resources such as facilities and community supports. There was not enough space to house individuals with mental illness. One participant in the justice system stated that:

The thing I find frustrating is the lack of facilities. We've had a couple of incidents here that probably shouldn't have happened just because of lack of facilities. And it's not a reflection at all on the staff, just they don't have the right kind of rooms and equipment to deal with this kind of situation.

A lack of resources in the community was also viewed as a barrier. There were limited support groups, information and education sessions, and outreach programs targeting mental health. One respondent working in the health system indicated that:

There is not much here and there hasn't been in terms of support groups. You know, that sort of thing. It's a rural population. So that would be something that I would see that would be lacking.

Another participant reported that:

Like you just don't have enough resources...whereas in larger centres, there's so much more to avail. There's probably a lot more outreach programs and stuff like that that you could refer clients to or work together with...whereas you've just got us sitting around a table, and you don't have probably a lot of the other resources to work with. So I think being in a rural area limits you.

*High workload among professionals*

High workload was another challenge. Even in a small community, one respondent indicated that: "we still do have a high volume of people with mental illness,"

so that professionals were forced to try and manage high workloads. Another professional felt that she had minimal time to spend with her patients/clients to deal with mental health issues. She stated that “if you had extra time to spend with your patient, you could nip the problem before it got too serious.” It was difficult to address mental health issues early on as professionals were forced to spend their time dealing primarily with more serious problems.

#### *Impact of the Rural Mental Health Interprofessional Training Program*

All of the participants had attended the Rural Mental Health Interprofessional Training Program (RMHITP) and were asked how this program had impacted their perceptions of collaborative practice. They listed a number of positive effects: increased understanding of other professions, expanded referrals, creation of new networks, and a validation of current practice. Also, many participants reported that their perceptions of interprofessional collaboration had not changed as a result of involvement in the program. Each will be described below.

##### *Increased understanding of other professions*

The main effect of the program seemed to be increased understanding of other professionals' roles. The program brought different professionals together from various systems to discuss their roles with respect to mental health care. The RMHITP served as a learning opportunity that expanded participants' understanding and provided them with a deeper knowledge of other professionals' roles. Focusing discussions on mental health care extended their awareness of other professionals' roles related to a specific health topic. For example, a professional from the health system stated that:

One of the things we did was we got together in groups and discussed what each other's roles were. So that helped me probably a little better, that there were

people who were able to do things that I didn't realize at the time. So I guess it broadened my knowledge of maybe a social worker. I had a general idea of what they did but I am more aware now of the other things maybe that they can do and stuff like that. And so I think it certainly helped with that aspect of it. It made me a little more aware of what exactly other professions could do.

#### *Expanded referrals*

This improved awareness of the other professionals' roles led professionals to refer patients/clients more often to other professionals. For example, a participant working in the health system stated that:

And even just finding out who is out there and what they do. Like those school counsellors, that was an eye-opener for me. I didn't realize they did as much as they did, the guidance counsellors at the schools. So it was just interesting to hear what other disciplines are doing. It's good referral points.

Another professional working in the education system said that participation in the program broadened her referral network.

In the past, it would be very common for me to involve doctors, nurses, and the mental health worker. I think now I would be far more inclined to call up Occupational Therapy, Physiotherapy, Recreational, and call on their strengths. It's really broadened what the team could do, the potential for the team members. It has kind of helped me think a little bit broader.

Another participant indicated that:

I have a greater understanding now of what people's strengths are in their jobs, and what more appropriate referrals would be like, exactly what people do. Like I had a sense of what a recreational therapist did but now I understand that far better.

#### *Creation of new networks*

Participants were able to identify new ways to work collaboratively as a result of the RMHITP. The program provided an opportunity for professionals working across systems to make new connections. In particular, including professionals from the community, education, and health systems was useful because it created new cross-

system collaboration. A participant working in the health system commented that: “It was stepping outside the institution into the community and knowing what all these people do which was a good learning experience.”

I guess from the project, though, some of the groups that were there, I hadn’t had much dealing with. For example, Recreational Therapy here at the hospital, I guess I saw some new ways they might become involved in client cases. So there were certainly benefits that way as well. And it’s great just to have everyone together discussing. So there were definitely those benefits.

One participant also described how the program provided an opportunity to form personal connections with other professionals. This helped to facilitate future instances of collaborative practice.

I have met a lot of people through this program that I hadn’t known in the community before...it wasn’t just hospital-based. Now I’ve got more connections for when I do have issues coming up...I’ve got a direct connection. I know the name, I know the person. They know me. As opposed to just calling some random person. So it’s a connection.

#### *Validation of current practice*

The RMHITP also seemed to formalize, confirm, and reinforce current practice. Participants perceived the program as a validation of what they had been doing in the community for the past number of years. One participant stated that:

Well I think people might be more conscious of it (interprofessional collaboration) just from doing the program and in terms of value of it, I mean being reinforced. But again, I’ve always felt that people come together around cases.

Another participant noted that:

So I think we were pretty well niched before. This (program) kind of just formalizes it more I guess probably more than anything else. I think this was more for us a pat of the back that we actually got it right sort of thing. Not that we couldn’t still learn obviously, and I think we did learn from this, but that we were heading in the right direction.

Another participant indicated that while interprofessional collaboration had been adopted and used in the community for a number of years, it had only been recently labelled as interprofessional collaboration. It was suggested that historically a lot of collaboration had happened, although over the past eight years practices became formalized.

We actually collaborated and didn't think anything of it kind of thing. But since we started putting names on it and naming teams and actually....and we didn't actually come together as teams, we just all collaborated. It was more like corridor consults and telephone consults. But we knew that the other person was there and that we could utilize them. But there was no formal team. So probably in the past 8 years what we have done is we have formalized the way we always did business. We formalized it and made formal teams. So that has made it even more effective.

*Perceptions of interprofessional collaboration unchanged*

Many of the participants stated that the RMHITP had little impact on their perceptions of collaborative practice. This is likely because the professionals were already strong proponents of collaboration and teamwork prior to the implementation of the program. It is therefore not surprising that they reported minimal change as a result of the RMHITP. Participants stated that they felt as valued and respected before the program as after. All of the professionals who participated in the study believed that openness and willingness to collaboration among professionals existed prior to participation in the training program. One participant stated that: "I think we did it well before...so I think we were always doing it...we are always doing the team thing here, and we have been for a long time." Another participant working in the health system noted that:

They (professionals) are very open. But like I said, this site has been like that for years, so I don't think the program has changed much per se. It may have made a few more connections between the community and the hospital.

One respondent who worked in the community commented that there was an egalitarian atmosphere among professionals before and after involvement in the program:

Oh good...like really, I don't think there was any hesitation before. I never felt any sense that anybody was anybody, and anybody was nobody. I thought we were all on a level playing field at every session. Yes it was good.

Overall, participants felt that collaboration has been and continues to be part of the culture in their rural community. Participants endorsed and valued interprofessional collaboration and were able to identify a number of advantages and benefits to this form of practice. Professionals also saw teamwork as a practice that worked well to treat mental health in a rural community. Given that mental health issues are often very complex, they believed that interprofessional collaboration was a means of providing comprehensive mental health care service delivery. Participants thought that by living in a rural community with few resources (human resources, facilities and programs), professionals were forced to rely on one another and work in teams.

## CHAPTER IV

### Discussion

In this chapter, the findings of this study are situated within the context of the literature on interprofessional collaboration, rural mental health, and the theoretical framework adopted for this study. Limitations of the study, implications for practice, and future research are also discussed.

Overall, participants in this research were very enthusiastic about interprofessional collaboration and articulated many advantages and benefits to this form of practice. When asked to describe some of the facilitators that have been identified in the research (trust, openness and willingness to collaboration, and mutual respect) to teamwork, participants quickly responded that these precursors to collaborative practice were already present among professionals in their community. By contrast, participants did not identify many challenges, disadvantages, or drawbacks to collaboration and required frequent prompting. Participants' motivations for adopting interprofessional collaboration were explored. Professionals described the community as having worked collaboratively for a long time. Teamwork seemed very much a part of the culture and history.

#### *How did Professionals Understand Interprofessional Collaboration?*

There was a great deal of unanimity among participants regarding their understanding of interprofessional collaboration. Professionals' explanations of collaborative practice did not differ based on their discipline. This contrasts with other research which has found discipline differences in their conceptualization of

interprofessional collaboration (Barker et al., 2005; Reese & Sontag, 2004; Liedtka & Whitten, 1998; Sicotte et al., 2002; Salmon, 2004).

Their conceptualization of interprofessional collaboration overlapped with the working definition adopted in this research, “conveying the idea of sharing and implies collective action toward a common goal, in a spirit of harmony and trust, particularly in the context of health professionals” (D’Amour et al., 2005). First, participants described experiences collaborating with other health professionals. Even though some participants worked in systems other than health, they still considered themselves health professionals. Second, they viewed the practice as goal-oriented. Third, participants identified trust as an enabler to collaborative practice. While participants did not specifically talk about a “spirit of harmony,” they described a shared understanding and their descriptions of the collaborative climate suggested that they had harmonious relationships.

Participants extended the definition of collaboration described above. One, they included both formal and informal occurrences as part of interprofessional collaboration. Two, they also elaborated the concept of collaborative practice by providing examples of working interprofessionally within a system as well as across systems. For example, grand rounds consisted of a collaboration within one system (health), while an Individual Support Services Plan meeting represented an inter-system (health, education, community, and justice if necessary) collaboration. These aspects of interprofessional collaboration have not been discussed in the literature. These findings suggest that interprofessional collaboration should be conceptualized more broadly to include both formal and informal practices occurring within and across systems.

*What did Professionals Perceive as Advantages to Collaborative Practice?*

Overall, participants were very enthusiastic about collaborative practice. They saw a number of advantages to interprofessional collaboration for both them professionally and for their patients/clients. They described enhanced opportunities for learning, increased feelings of support, feeling valued and respected by their peers, improved decision-making, enhanced quality of care, as well as had advantages for mental health care. Enhanced quality of care is consistent with previous research, which indicated that interprofessional collaboration has led to improved patient care (Zwarenstein, 2005; Zwarenstein & Bryant, 2000; Baggs & Schmitt, 1997; D'Amour et al., 2005; Henneman et al., 1995).

Participants stated that interprofessional collaboration enhanced their learning. They learned from each others expertise, expanded their knowledge, and participated in sharing and exchanging information. Comparable findings were noted by Baggs and Schmitt (1997) who indicated that interprofessional collaboration created increased opportunities to exchange information across disciplines and learn from other professions.

Consistent with findings from this study, earlier work (Zwarenstein & Bryant, 2000; D'Amour et al., 2005) suggests that increased collaboration improved staff satisfaction. While participants did not specifically identify job satisfaction as a gain, their comments about increased support and feeling valued and respected implied feeling satisfied. Similarly, Henneman and colleagues (1995) found that professionals who engaged in interprofessional collaboration benefited from a supportive and nurturing work environment.

Participants in this research felt that interprofessional collaboration provided an opportunity to bring a range of professionals together who have a variety of backgrounds, skills, and experiences. This process resulted in improved decision-making and patients/clients having access to a range of expertise from a variety of professionals. This is similar to the Baggs & Schmitt's (1997) study which found that professionals felt that interprofessional collaboration resulted in improved decision-making.

One finding from this study that has not been identified in the literature is that interprofessional collaboration may be advantageous in treating mental health in a rural community. Participants of this study stated that collaborating worked well because it provided a goal-oriented approach to treatment, targeted the complex needs of the patients/clients, and helped keep patients/clients in their home community. There are often few resources in rural communities and participants felt that interprofessional collaboration was a mechanism for maximizing resources. Health administrators and managers may want to find ways to encourage professionals to work collaboratively. Examples could include financial reimbursement for collaborative activities, incentives to participate in interprofessional education, and being flexible with professionals' schedules (e.g. allotting time for collaborative practice activities). This may offset some of the drawbacks to interprofessional collaboration and may increase the likelihood that professionals engage in this form of practice.

#### *What did Professionals Perceive as Drawbacks to Collaborative Practice?*

As noted in the prior chapter, professionals described few disadvantages to collaboration. While interprofessional collaboration was identified as time consuming and a drawback in the short-term, participants reported positive benefits over time

including enhanced and more efficient care. This is consistent with earlier work indicating that time is viewed as both a barrier and advantage to interprofessional collaboration (Baggs & Smitt, 1997).

Participants discussed the lack of anonymity as a difficulty when collaborating in a rural area. The smallness of the community could create a resistance when seeking treatment for mental health. This is consistent with other research in mental health practice in rural communities where professionals often found it challenging to maintain client privacy and professional boundaries (Barbopoulos & Clark 2003; NARMH, 2000; Thorngren, 2003).

### *Theoretical Framework*

As described in Chapter One, organizational theory was adopted as the theoretical framework for this study. It consists of three levels: the interactional level (interpersonal relationships between professionals), the organizational level (organizational factors), and the systemic level (conditions outside the organization) (D'Amour et al., 2004). The findings regarding facilitators and barriers to collaboration are discussed in relation to this framework.

#### *Interactional level*

Professionals identified familiarity and trust as enablers to collaborative practice. Because many had worked in their positions for a number of years, they felt that familiarity and trust had developed over time. This finding is consistent with other work. Martin-Rodriguez and colleagues (2005) identified trust and a clear definition and understanding of professional roles as necessary for effective collaborative practice.

Participants felt that strong connections and commitment to the community facilitated interprofessional collaboration. As mentioned, many of the professionals interviewed were from the area. This facilitator has not been identified in the interprofessional collaboration literature to date, perhaps because there has been little research on teamwork in rural communities. Overall, participants in this study focused most on the interactional level when discussing potential enablers to collaboration. This is consistent with previous work that has focused heavily on facilitators to collaboration operating at the interactional level (Martin-Rodriguez et al., 2005; Hacker & Wessel, 1998; Henneman et al., 2005).

#### *Organizational level*

Even though the literature has described enablers and barriers to working interprofessionally operating at an organizational level (Martin-Rodriguez et al., 2005; Barker et al., 2005; Salmon, 2004; D'Amour et al., 2004; Darlington et al., 2005; et al., Janssen et al., 2004), participants did not identify any facilitators or challenges to teamwork at this level.

#### *Systemic level*

Half of the professionals mentioned being recognized as a primary health care site as a facilitator to interprofessional collaboration. This was a systemic level intervention because it provided money and structures that initiated and fostered collaborative practice in the community. This finding has not been discussed in the literature.

Unlike the literature that has identified numerous barriers to working in teams (Darlington et al., 2005; Oandasan & Reeves, 2005; Janssen et al., 2004; Barker et al., 2005; Liedtka & Whitten, 1998; Sicotte et al., 2002; Reese & Sontag, 2001), participants

in this study only identified one challenge. A minority of participants felt that lack of commitment by physicians was a barrier to interprofessional collaboration because not all disciplines were represented. They offered some possible explanations for physicians' lack of involvement such as inadequate staffing, time constraints, and high turnover rates, which are systemic level concerns. This is consistent with a finding from the two pilot studies of the Rural Mental Health Interprofessional Training Program, where it was difficult to engage the physicians in the program (Cornish et al., 2003; McVicar et al., 2005). In the pilot studies, non-attendance by physicians was interpreted by other professionals as an unwillingness to participate and a lack of commitment to teamwork.

#### *Challenges of Treating Mental Health in a Rural Community*

Overall, participants felt that resources were lacking in their community. They did not have sufficient facilities to house individuals with mental illness, there were few community supports for patients/clients and their families, there were not enough staff, and many professionals had minimal training and experience in treating mental health. Patients/clients were often forced to travel long distances to receive mental health services and issues with transportation, geography, and weather conditions were common. Participants also felt that there is a stigma attached to mental illness in a rural community that creates a resistance to accessing services. These findings are consistent with previous research. The Canadian Institute of Health Information (2006) report comparing the health status of rural and urban populations found that individuals who live in rural areas are forced to travel longer distances on more dangerous roads. Similarly, Hutten-Czapski (2001) found that one of the main difficulties in rural areas when providing health care service delivery is the persistent shortage of health care

professionals. The lack of staff means that patients/clients are required to travel to access specialized services, which generates transportation and travel issues (Barbopoulos & Clark, 2003). Thorngren's (2003) study found that the stigma attached to mental illness was also a challenge for the practice of mental health care in a rural area.

#### *Impact of Systemic Level Intervention*

As discussed earlier, all participants who participated in this study attended the Rural Mental Health Interprofessional Training Program (RMHITP). This training program can be considered a systemic level intervention. As noted in the literature review, interprofessional education has been hypothesized to potentially increase instances of collaborative practice (Health Canada, 2004). Professionals were asked to describe how their participation in the RMHITP impacted their perceptions of collaborative practice. Most commonly they felt that attending the RMHITP increased their understanding of other professionals' roles. This finding was noted in the two pilot studies, where professionals who participated in the training program described improved collaborative practice and increased awareness of the roles and responsibilities of other disciplines (Cornish et al., 2003; McVicar et al., 2005).

Professionals also stated that participation in the program provided enhanced opportunities for referral, collaboration, and created new networks. The RMHITP brought a variety of disciplines together who worked in a number of systems. Having the chance to discuss each others' roles with respect to mental health care increased collaboration among professionals both within systems and across systems. Additionally, participants noted that they were able to form personal connections with one another by

attending the program, and they felt this would strengthen future occurrences of collaboration.

*Can Interprofessional Collaboration Address the Challenges Associated with Treating Mental Health Care in a Rural Community?*

According to participants of this study, one of the gains associated with interprofessional collaboration was providing efficient and appropriate care in treating mental health. Participants believed that working in a rural community facilitated teamwork, because professionals had to reach out to their co-workers in the community for service delivery. This is consistent with Smith's (2003) research that suggested collaboration may be a means of treating mental health in a rural area. This provides some support for the suggestion that teamwork may address some of the challenges of treating mental health in a rural area.

*Limitations*

Not all the professionals who worked in mental health participated in this study, as a result not all professions from the community were represented. Even though professionals from nine different disciplines, working in four different systems were represented, there were other professionals in the community who did not participate and they may have other views about interprofessional collaboration. Furthermore, it is possible that there was a bias in the response rate. It may be that those professionals who did participate in the study were more engaged and enthusiastic about interprofessional collaboration than those who did not volunteer. Their willingness and openness to collaboration may have made it more likely that they would be eager to participate in the

interviews and thus their perspectives may not be representative of all the mental health professionals in the community.

Although nine professional groups were interviewed, for the most part, there was only one representative from each discipline. Furthermore, in some instances there was only one participant working in a particular system (e.g. education). Also, the interviews were only conducted in one community. Therefore, the results of this study are specific to a particular context in rural Newfoundland, and the generalization of these results is limited. This, of course, is generally true of qualitative research.

As mentioned in Chapter Two, participants were interviewed seven weeks after completing the Rural Mental Health Interprofessional Training Program. When asked to describe the impact of the program on their perspectives of interprofessional collaboration, they were reflecting retrospectively. Participants may not have recalled specific details about their involvement in the program that may have impacted their views of collaborative practice. Results may have varied if the interviews had been done immediately following participation in the program. Seven weeks may have given participants more time to reflect on their experiences in the training program, how their involvement may have influenced their perceptions of interprofessional collaboration, and their practice of working in teams.

### *Implications*

#### *Implications for interprofessional collaboration*

The findings of the current study have implications for our understanding of interprofessional collaboration. Based on responses, it is likely that we need to conceptualize interprofessional collaboration more broadly to include formal and

informal practices working within and across systems. Policy makers could facilitate collaborative practice by creating more opportunities for information sharing and exchange, providing a space for professionals to come together, as well as allowing professionals adequate time to participate in collaborative activities and to develop positive working relationships with their colleagues.

Also, this research has highlighted the importance of considering community connections as an important facilitator to interprofessional collaboration at the interactional level. It may be that health professionals may be more apt to engage in this form of practice if they have a pre-established connection with the community, the public, and with the other professionals working in the area. Policy makers may want to consider establishing recruitment practices for professionals that reimburse individuals for a portion of their training with an agreement that they will return to their home community to provide service post-graduation. This has been done mostly with physicians and it may be beneficial to expand this incentive to include a variety of disciplines.

#### *Implications for rural mental health care*

This research also has implications for the field of rural mental health care. As noted in the first chapter, the research in this area is scarce. However, the findings of this study lend support to previous findings indicating that a lack of facilities and programs, few human resources, and high workload contribute to challenges in treating mental health in a rural community. Participants in this study felt that interprofessional collaborative practice may be a means of addressing some of the challenges of working in a low-resourced environment. In fact, having fewer resources may encourage more

collaborative care. Policy makers may want to consider offering more training programs and interprofessional education opportunities. This may increase professionals' likelihood to work collaboratively and in teams.

#### *Implications for training programs*

The findings of this study also have implications for training programs such as the RMHITP. Participants identified that the process of coming together as a group was as valuable, if not more valuable, than the content of the sessions. It is important to have representatives from a wide range of disciplines and systems in these kinds of programs. In the case of this study, participants noted that having this representation increased instances of inter-system collaboration. Training programs should also incorporate a discussion of professionals' diverse roles and responsibilities. Participants viewed this activity as beneficial because it increased their understanding of each others' roles and created novel networks among individuals working in the same system, as well as across systems. It may be helpful for future interprofessional education activities to include professionals from across systems. Since most interprofessional training has focused on collaboration among health professionals, it could be useful to include disciplines from systems other than health (e.g. education, justice, and community). This may increase chances for professionals to develop novel inter-system as well as intra-system connections.

#### *Recommendations for Future Study*

While a great deal of information was generated in the current study, there is potential to learn more about the perceptions of interprofessional collaboration and rural mental health practice. Future research could be replicated in other rural communities in

order to see whether similar perceptions and understanding of interprofessional collaboration are shared by professionals in other rural locations. As well, it might be beneficial to compare perceptions of collaborative practice in urban and in rural areas, as it is possible that professionals practicing in urban settings may have different views of interprofessional collaboration.

As noted in this research, professionals who were interviewed perceived teamwork to be a means of overcoming the challenges faced when providing mental health care in rural regions. While these findings are specific to one small community, it is possible that professionals working in other rural communities may share or oppose this same perspective. Exploring this research question in other rural areas of Atlantic Canada would be most useful in determining if this finding is supported by other participants in the region.

Participants of this research identified features unique to their community as contributing to effective collaboration including familiarity with one another, pre-established trust, being located in a rural area, as well as a connection and commitment to the community. They were also very keen and enthusiastic about teamwork and appeared to be already practicing collaboratively. Future research could use a more in-depth design, such as an ethnographic study. This type of research may generate additional detailed information about the practice of collaboration in the community and perhaps offer some further insight into the reasons why teamwork appears to be working so well in this area.

Finally, one of the challenges to interprofessional collaboration noted in this study, as well as in other research (Cornish et al., 2003; McVicar et al., 2005) is low

physician involvement. While this has been identified as an inhibitor to collaborative practice, few reasons have been offered for this lack of participation. Since physicians are a critical part of interprofessional collaboration, it may be useful to conduct research with physicians in order to better understand why they appear to be less involved than many other professions.

### *Conclusion*

Professionals who participated in this study appeared to be very passionate about the practice of collaborating and working in teams. Their enthusiasm and belief in interprofessional collaboration was evident by their lengthy discussions of the benefits to this form of practice, both for them professionally and for their patients/clients. Not only did they identify the advantages to working in teams reported in previous research including improved quality of care, enhanced opportunities for learning, feeling valued and respected, and having increased support, they also felt that working collaboratively had direct benefits for rural mental health care, an opinion that has not been reported in the literature to date. This has implications for the field of mental health care. Given the challenges of working in a rural area to treat mental health that have been identified by participants in this study and prior research, interprofessional collaboration may be a means of addressing these barriers. The practice of interprofessional collaboration may differ in a rural community compared to an urban setting. Future research should investigate collaborative practice among other professionals treating mental health in rural settings in order to determine if they share similar views as the participants in this study.

As stated in Chapter Two, in the phenomenological approach, the researcher needs to consider how his or her own subjective values, biases, experiences, and expectations may have impacted his or her interpretation of the research context, data collection, and data analysis. Having grown up in a rural community, I became more aware of my understanding of the benefits of working as a professional in a small community. When visiting the community and conducting the interviews, I became more aware of my passion for mental health issues and my appreciation for the barriers to mental health service delivery in a rural area. Having worked in the school system, my experiences collaborating across disciplines have been within one system. The findings of this thesis helped me see the benefits of working in teams across systems.

Even though many obstacles to interprofessional collaboration have been identified in past research, such challenges were not identified by participants in this study. Professionals only referenced one inhibitor to this practice. Instead, participants described numerous facilitators to collaborative practice such as connection to the community, working in a rural setting, physical proximity, and familiarity and trust. Their connection and commitment to the community seemed to strengthen collaborative practice, a finding that has not been discussed in the literature to date. Furthermore, participants felt that being located in a rural setting with few resources fostered a sense of teamwork. Professionals were forced to reach out to others in their community for support and in order to provide care to patients/clients. This study provided an example of the many advantages for both professionals and for their patients/clients as a result of working in teams. This illustrates how beneficial interprofessional collaboration can be for professionals when it is endorsed, valued, and working well in a community.

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## Appendix A

**Questions:**

1. What is your professional/occupational area?
2. How long have you worked in your community?
3. How many years of experience do you have in your professional role?
4. What kind of involvement do you have in mental health activities in your community?
5. What have you found works well when treating clients in a rural community who have mental health issues?
6. What are the challenges in your work in a rural community with clients who have mental health issues?
7. Please describe what interprofessional collaboration means to you? How has your understanding changed as a result of your involvement in the program?
8. Describe an experience you have had collaborating across disciplines and working in teams. What impact will your involvement in the program have on future experiences collaborating across disciplines and working in teams?
9. With which other professionals do you collaborate most frequently? How has this changed as a result of the program?
10. What advantages and disadvantages do you see professionally in terms of collaborating with other disciplines in a rural community to treat clients who have mental health issues?
11. What benefits and drawbacks do you anticipate for the patients/clients as a result of collaborating with other health care professionals in a rural community to treat mental health issues?
12. In your own professional education and training, how was collaboration and working in teams taught or modeled?
13. In your relationships with other health care professionals in your community, how much do you feel respected and valued? How has this changed with your involvement in the program?
14. How open and willing do you think professionals in your community are to working together now as compared to before the program?

15. How has the program impacted your work with patients/clients?
16. Based on your experiences living in a rural community, describe some of the factors you believe would promote the practice of interprofessional collaboration. [*leadership, group cohesiveness, money, resources, trust, open communication, mutual respect*]
17. Based on your experiences living in a rural community, describe some of the issues that may inhibit the practice of interprofessional collaboration. [*resources, time, money, professionals not knowing much about other discipline*]
18. Now that you have gone through the program, how important do you consider collaboration across disciplines in a rural community to treat clients with mental health issues?

## Appendix B

**Interview Consent Form*****An Exploration of Perceptions of Interprofessional Collaboration and Rural Mental Health Care*****Estimated Time: 30-60 minutes**

I, Jennifer Kilfoil, am a graduate student in the Faculty of Education at Mount Saint Vincent University in Halifax, Nova Scotia. As part of my Master's of Arts in School Psychology Program, I am conducting research to fulfill the thesis requirements under the supervision of Dr. Elizabeth Church. I am inviting you to participate in my study, *An Exploration of Perceptions of Interprofessional Collaboration and Rural Mental Health*.

Introduction: The objectives of this research are two-fold: to find out about professionals' perceptions of interprofessional collaboration and to examine some of the issues associated with treating mental health in a rural community. To do this, I am conducting interviews with professionals who have participated in the Rural Mental Health Interprofessional Training Program. The questions will ask you about your experience of being involved in the training program, your perceptions of interprofessional collaboration and your ideas about treating mental health care in your community. The interviews will be audiotaped and transcribed, with all identifying details removed.

Participation: You have been invited to take part in an interview. The interview should take between 30-60 minutes. During this interview, you will be asked to discuss your ideas about interprofessional collaboration and rural mental health care practice. It is important to note that this is a research project and participation in this project is voluntary. Along with the other participants, you will be invited to participate in a videoconference where I will outline my initial findings and ask for your feedback. Involvement in this aspect of the project is also voluntary. If you are interested in receiving a summary of the results, please list your name and contact information at the end of this form.

Confidentiality: I will conduct the interview. When reporting findings, you will not be identified in any way nor will the information presented, including direct quotes, identify you in any way. The transcriptions from the audiotapes will be stored in a locked cabinet for seven years after completion of the thesis requirements at Mount Saint Vincent University. Only my thesis supervisor (Dr. Elizabeth Church) and I will have access to the transcriptions.

Risks: The potential risks to your taking part in this interview are small. Anything you discuss with me will remain confidential and will not be shared with others. If you feel you would like to take a break or stop the interview completely for any reason, you may do so by letting me know.

Benefits: There is likely to be little direct benefit to you by taking part in this interview.

More Information: If at any time you would like more information about the project, please feel free to contact me, Jennifer Kilfoil, at [REDACTED] or by email at [REDACTED] or you may also contact Dr. Elizabeth Church at (902) 457-6721 or by email at [elizabeth.church@msvu.ca](mailto:elizabeth.church@msvu.ca).

In the event that you have difficulties with, or have questions about any aspect of this study and wish to speak with someone who is not directly involved in the study, you may also contact the Chair of the University Research Ethics Board (UREB) c/o MSVU Research and International Office, at (902) 457-6350 or via email at [research@msvu.ca](mailto:research@msvu.ca)

*IN SUMMARY:*

I understand that:

- This research is being conducted to fulfill the thesis requirements for the Masters of Arts in School Psychology at Mount Saint Vincent University.
- All information I provide will be kept confidential.
- My name will not be used in any discussions or publications about the research and will not be kept once the interviews are completed.
- The potential benefits and risks for me as a participant are small.
- I do not have to answer any question if I so choose and I can withdraw from the project at any time.
- I will keep a copy of this consent form for my own records.
- If I have any questions or concerns about this research, I can contact Jennifer Kilfoil at [REDACTED] or Dr. Elizabeth Church at (902) 457-6721.

I have read the explanation about the study and had the study explained to me. I have been given the opportunity to discuss it and ask questions. I hereby consent to take part in this study, however, I realize that this is voluntary and I am free to withdraw from the study at any time without penalty.

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher: \_\_\_\_\_ Date: \_\_\_\_\_

If you would like to receive a summary of the results of this study, please list your name and your email or address:

Name: \_\_\_\_\_

Email or address: \_\_\_\_\_