Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

# Interprofessional Education Initiatives in Collaborative Mental Health Care

10

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**Authors**
Jonathan McVicar, Memorial University of Newfoundland
Diana R. Deacon, Memorial University of Newfoundland
Vernon Curran, Memorial University of Newfoundland
Peter Cornish, Memorial University of Newfoundland

**Steering Committee Reviewers**
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Darene Toal-Sullivan, representing the Canadian Association of Occupational Therapists

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Enric Ribas, Designer
Shelley Robinson, Administrative Assistant

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Canadian Collaborative Mental Health Initiative Secretariat
c/o College of Family Physicians of Canada
2630 Skymark Avenue, Mississauga, ON L4W 5A4
Tel: 905-629-0900 Fax: 905-629-0893
E-mail: info@ccmhi.ca Web site: www.ccmhi.ca

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# INTERPROFESSIONAL EDUCATION INITIATIVES IN COLLABORATIVE MENTAL HEALTH CARE

*A paper for the*
*Canadian Collaborative Mental Health Initiative*

Prepared by:

Jonathan McVicar, PhD
Project Coordinator, Rural Mental Health Interprofessional Project
Assistant Professor, Memorial University of Newfoundland (MUN) Counselling Centre
Centre for Collaborative Health Professional Education
Faculty of Medicine, Memorial University of Newfoundland

Diana R. Deacon, M.Ad.Ed.
Health Professional Education Specialist
Centre for Collaborative Health Professional Education
Faculty of Medicine, Memorial University of Newfoundland

Vernon Curran, PhD
Director of Research and Development
Associate Professor (Medical Education)
Centre for Collaborative Health Professional Education
Faculty of Medicine, Memorial University of Newfoundland

Peter Cornish, PhD
Associate Professor, Memorial University
Director, Memorial University Counselling Centre
Memorial University of Newfoundland

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# O U R  G O A L

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

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# EXECUTIVE SUMMARY

Collaborative mental health care has been identified as a key to enhancing the mental health services provided to consumers, their families, and their caregivers in the community. However, there are a number of barriers to enhancing collaborative mental health care, including a lack of understanding among health care professionals about the expertise of other mental health providers; lack of knowledge and skills in collaborative mental health care; and negative attitudes toward teamwork and collaboration. These challenges may be the result of how health professionals are educated and trained. It is believed that interprofessional education can increase awareness and understanding of the roles of other health professionals, as well as fostering more positive attitudes toward teamwork and collaborative mental health care.

While conducting a literature review on collaborative mental health care, the Canadian Collaborative Mental Health Initiative (CCMHI) found that the lack of mental health care training for primary health care professionals, as well as the lack of collaborative or interprofessional educational opportunities, were barriers to front-line care. Interprofessional education programs were viewed as a potential solution to this problem, and as a result, the CCMHI commissioned the Centre for Collaborative Health Professional Education (CCHPE) to survey the current state of collaborative mental health care education among a number of groups, including the following: Canadian universities and colleges; national and provincial professional/territorial associations; national and provincial/territorial regulatory organizations; and mental health advocacy societies and associations. Online surveys were conducted to gather the information.

## Objective

The purpose of this study was to examine the level and specific characteristics of interprofessional education offered in collaborative mental health care across Canada. The focus was on current training offered at the pre-licensure (undergraduate- and graduate-level education) and continuing education levels. This objective aligns with the overall goal of the CCMHI, which is to improve the mental health and well-being of Canadians by enhancing the relationships and improving collaboration among health care providers, consumers, families and caregivers.

## Survey: Phases I and II

The CCMHI Steering Committee commissioned the two phases of the study. Phase I focused primarily on pre-licensure training conducted in Canadian universities and colleges. The Steering Committee then extended its search to the larger community, and Phase II focused primarily on post-licensure education or continuing education of health care professionals at a community-wide level.

The CCHPE developed and administered the online, Web-based surveys in both English and French, based on CCMHI guidelines. Input was also sought from the CCMHI Steering Committee and Dr. Peter Cornish, Director of the Counselling Centre at the Memorial University of Newfoundland.

## Conclusion

The majority of respondents do not presently offer formal pre-licensure, post-licensure, or continuing interprofessional education involving collaborative mental health care. However, they do support and encourage the development of interprofessional bridges and an appreciation for the skills and approaches that the various disciplines can bring to mental health care.

Some of the barriers to interprofessional education include a lack of financial resources, scheduling concerns, a lack of administrative/ executive support, rigid curriculum, and a lack of reward for faculty. Some of the enablers that can encourage the development of this type of education include: access to time and resources, financial support, and increased communication and collaboration.

Key recommendations for interprofessional education in collaborative mental health care, include the following:

- fostering co-operation and collaboration among faculty members, senior administrators, and other key players within existing institutions to support the development of interprofessional education in collaborative mental health care
- addressing logistical barriers, such as rigid curriculum and scheduling concerns, to make interprofessional courses more accessible
- allocating more funding to create and sustain interprofessional education, as well as to reward faculty members responsible for the programs

Despite the apparent scarcity of interprofessional education in collaborative mental health care, there appears to be a willingness among the various professional groups to develop interdisciplinary working relationships and to accept and value the skills everyone brings to the practice of mental health care.

# INTRODUCTION

It has been suggested that a greater engagement in collaborative mental health care is a key means of enhancing the quality and co-ordination of care provided to consumers, families, and caregivers in the community. Health care promotion and illness prevention can also be better addressed using the diverse perspectives available through collaborative mental health care. However, key challenges in fostering collaborative mental health care include a lack of understanding of the roles and expertise of other health care partners; a lack of knowledge and skills related to collaborative mental health care; and negative attitudes toward teamwork, collaboration and other professions. It has been suggested that deficiencies in knowledge, skills, and attitudes pertaining to collaborative mental health care result from the way health professionals are educated and trained: traditionally, they are trained in isolation from one another and, as a result, receive little exposure to the expertise of other professions.

Interprofessional education has been defined as "*occasions when two or more professions learn from and about each other to improve collaboration and the quality of care*."[1] Interprofessional education can do the following:

- enhance awareness and understanding of the role and expertise of other professions
- foster positive attitudes about teamwork and collaborative mental health care
- overcome negative stereotyping
- improve the health care competencies of health professional learners

While conducting a literature review on collaborative mental health care, the Canadian Collaborative Mental Health Initiative (CCMHI) found that the lack of both mental health training for primary health care professionals and collaborative or interprofessional educational opportunities were barriers to front-line care. Collaborative or interprofessional education programs were viewed as a potential solution to this problem, and, as a result, the CCMHI Steering Committee commissioned Phase I of this study. Phase I focused primarily on undergraduate- and graduate-level training offered in Canadian universities and colleges. After reviewing the results of this phase, the CCHMI Steering Committee extended its search to the larger community, hypothesizing that collaborative mental health care education may not be limited to institutions of higher learning. Phase II was subsequently commissioned to focus primarily on post-licensure or continuing education of health care professionals at a community-wide level.

The Centre for Collaborative Health Professional Education was given the task of surveying the current state of pre- and post-licensure collaborative mental health care education among several groups: Canadian universities and colleges; national and provincial professional/territorial associations; national and provincial/territorial regulatory associations; and mental health advocacy societies and associations.

The intent of this commissioned report was to provide a snapshot of current interprofessional education initiatives in collaborative mental health care. The intent of the CCMHI Steering Committee is to obtain an accurate baseline picture of these educational initiatives, which

will contribute to the development of an educational toolkit. This toolkit can then be used to further develop interprofessional educational programs across the country.

The Steering Committee also intends to develop collaborative mental health care beyond its current state by doing the following:

- designing a series of toolkits for clinicians, policy-makers, educational leaders, consumers, families, and caregivers
- drafting and signing a charter that would promote the development of collaborative mental health care in the directions defined by the CCMHI Steering Committee members. Namely, the Steering Committee is committed to the following:
  - promoting collaborative mental health care that enhances the entire continuum of care, from prevention to rehabilitation
  - providing tools that enable a range of necessary providers to overcome noted barriers and collaborate to provide more integrated mental health and physical care
  - upholding the notion that consumers and caregivers are experts in their own right and are to be respected partners in determining treatment options; setting goals for recovery; and developing collaborative mental health care initiatives and program evaluations

## Method

A Web-based survey was developed based on information obtained from consultation with the CCMHI Steering Committee and Dr. Peter Cornish, Director of the Counselling Centre at the Memorial University of Newfoundland.

The survey consisted of the following sections:

- background information on the group (organization/association/institution) participating in the survey
- description of courses/workshops/modules offered at the pre-licensure, post-licensure, or continuing education level
- group (organizational/association/institutional) goals and beliefs related to interprofessional collaboration and training
- barriers to and enablers of education for collaborative mental health care

The survey was piloted with members of the CCMHI Steering Committee prior to dissemination. It was then made available online in English and French using an online survey tool (www.surveymonkey.com). Copies of the survey are included in Appendices B (Phase I) and C (Phase II).

E-mails in English or French inviting participation in the Web-based survey were sent to senior administrators, executive directors, presidents, chairs, and leaders of groups involved with training, administration and delivery of mental health services in Canada. A reminder e-mail was sent to all potential participants one month after the initial e-mail contact (see Appendices D [Phase I] and E [Phase II]). Academic units, national/provincial/

territorial associations and regulatory bodies were invited to participate. In addition, mental health advocacy societies, consumer groups, and associations in dietetics, medicine/family medicine, nursing, occupational therapy, pharmacy, psychology, social work, and psychiatry were represented (a complete e-mail distribution list is available from the CCMHI).

Survey responses were downloaded from the Web site and analyzed. Qualitative responses were collected and analyzed for key emerging themes, issues, and groupings.

# RESULTS FROM PHASE I

**Description of respondents: response rates and breakdown by professional group**

A total of 236 (194 English, 42 French) contacts were invited to participate in the Phase I survey, and 36 (34 English, 2 French) responses were received. The response rate for Phase I was 15.3% (17.5% for the English survey; 4.8% for the French). The majority of respondents for the English survey were from nursing, medicine, and occupational therapy (see Table 1 and Figure 1). Responses for the French survey came from the faculties of medicine and social work.

table 1 **Response rates and breakdown by professional group (Phase I)**

| Professional Group | Dietetics | Medicine | Nursing | Occupational therapy | Pharmacy | Psychology | Social work | Family medicine | Psychiatric medicine | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| English Surveys | | | | | | | | | | |
| Total | 13 | 13 | 79 | 16 | 7 | 19 | 21 | 14 | 13 | 195 |
| Number sent successfully✦ | 13 | 13 | 78 | 16 | 7 | 19 | 21 | 14 | 13 | 194 |
| Number not able to be sent■ | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Number responses | 0 | 7 | 15 | 7 | 1 | 4 | 0 | n/a• | n/a• | 34 |
| Per cent total responses (n=34) | 0 | 20.6 | 44.1 | 20.6 | 2.9 | 11.8 | 0 | n/a• | n/a• | n/a• |
| Per cent total contacts for profession | 0 | 53.8 | 19.2 | 43.8 | 14.3 | 21.1 | 0 | n/a• | n/a• | 17.5 |
| French Surveys | | | | | | | | | | |
| Total | 3 | 3 | 9 | 2 | 2 | 8 | 9 | 3 | 3 | 42 |
| Number sent successfully✦ | 3 | 3 | 9 | 2 | 2 | 8 | 9 | 3 | 3 | 42 |
| Number not able to be sent■ | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Number responses | 0 | 1 | 0 | 0 | 0 | 0 | 1 | n/a• | n/a• | 2 |
| Per cent total responses (n=34) | 0 | 50 | 0 | 0 | 0 | 0 | 50 | n/a• | n/a• | n/a• |
| Per cent total contacts for profession | 0 | 33.3 | 0 | 0 | 0 | 0 | 11.1 | n/a• | n/a• | 4.8 |

✦ *Messages sent without "message undeliverable" responses.*
■ *Messages sent with "message undeliverable" responses and no alternative contact available.*
• *Not available*

**Current status of pre-licensure interprofessional collaborative mental health care education**

The majority of respondents (64.6%) indicated that no formal interprofessional courses/workshops/modules for collaborative mental health care exist for their discipline, but that teaching philosophies and practices that promote collaborative mental health care are encouraged (see Table 2). It should also be noted that although 16 respondents indicated that formal courses/workshops/modules existed in their discipline, only six provided a description.

figure 1 **Percentage of total responses by professional group (Phase I, English)**

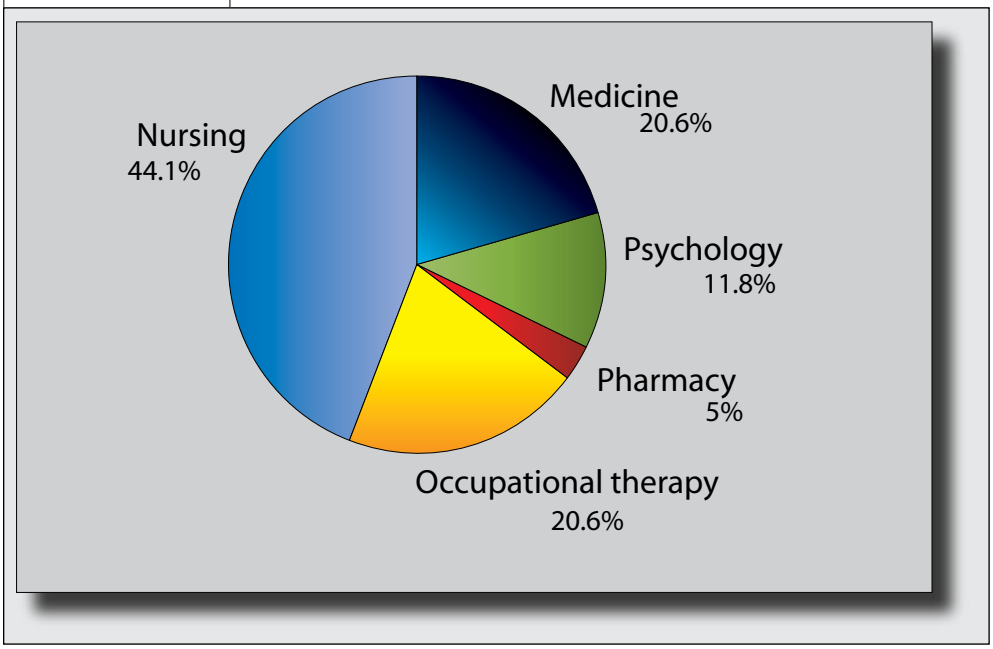



table 2 **Current status of interprofessional education for collaborative mental health care (Phase I)**

| Which of the following statements best describes the current status of interprofessional education for collaborative mental health care in your institution and for your discipline? | % | Total |
|---|---|---|
| Students/learners in our discipline participate in some type of formal interprofessional education course/workshop/module that has focused on collaborative mental health care | 33.3 | 16 |
| **No formal interprofessional courses/workshops/modules for collaborative mental health care exist for our discipline, but teaching philosophies and practices that promote collaborative mental health care are encouraged** | **64.6** | **31** |
| Our discipline does not currently offer formal courses/workshops/modules or promote teaching philosophies/practices that encourage collaborative mental health care | 2.1 | 1 |

## Descriptions of programs

Respondents who indicated that their institution offered formal courses, workshops, or modules on collaborative mental health care were directed to a separate survey section designed to collect more detailed descriptions of the programs (see Appendix B, Section 1). Six institutions responded with descriptions of eight formal courses/workshops/modules (see Table 3). These institutions were located in Vancouver and Surrey, British Columbia; Medicine Hat and Calgary, Alberta; Hamilton, Ontario; and St. John's, Newfoundland. Three responses were from nursing programs, two were from faculties of medicine, and one was from a department of health studies. Appendix F summarizes the eight program descriptions submitted.

Four of the described courses (Health of Specific Populations, Therapeutic Communication, Bioethics, and Psychiatric and Mental Health Nursing) are part of undergraduate programs. Of these, the Therapeutic Communication and Bioethics courses provide students with skills and knowledge that apply to their present studies and practice, as well as to future professional programs. The Therapeutic Communication course is the only reported course specifically designed for students in a variety of health-related programs. The Health of Specific Populations and Psychiatric and Mental Health Nursing courses are specialized undergraduate-level courses that focus on specific populations or areas of practice related to mental health care.

table 3 **Courses offered according to level of study**

| Pre-licensure courses | Post-licensure courses | Both pre- and post-licensure courses |
|---|---|---|
| Health of Specific Populations: School of Nursing, University of British Columbia<br>Therapeutic Communication: Division of Health Studies, Medicine Hat College<br>Psychiatry Emergency and Crisis Intervention (PEACI): Faculty of Medicine, Memorial University of Newfoundland<br>Behavioural Science: Faculty of Medicine, McMaster University<br>Psychiatry residency: Faculty of Medicine, McMaster University. | Psychiatry for Family Physicians: Faculty of Medicine, McMaster University | Bioethics: Faculty of Community and Health Studies, Kwantlen University College<br>Psychiatric and Mental Health Nursing: School of Nursing, Mount Royal College |

Three of the courses (Psychiatric Emergency and Crisis Intervention, Behavioural Science, and the Psychiatry residency) are part of medical residency programs. One continuing medical education (CME) program in psychiatry for family physicians was described. Program descriptions for these courses included topics such as working in multidisciplinary teams; promoting mental wellness; working in a variety of levels (primary, tertiary) and settings (acute care, family practice, community-based); teaching about mental health care at a practical/clinical level; and helping practitioners work in a "shared care" model.

Although all submissions referred to goals such as working in multidisciplinary teams, only one included students from more than one profession.

A variety of learning activities and assessment activities were reported. The most frequently noted learning activities included didactic and small-group instruction, followed by large-group discussion, case-based learning, and role-playing. Problem-based learning, the use of standardized consumers, and learning activities involving direct service to consumers were also noted. The most frequently noted assessment activities included self-assessment, role-play, objective testing, group projects, and review of video- or audiotapes.

## Successful programs: helpful and hindering factors

At the end of section 1 of the survey, respondents were asked what they felt was most successful and least successful about the courses described. The six respondents provided some of the following information about what they felt made the course a success (a complete listing of responses is available from the CCMHI):

*Multidisciplinary learning, case-based learning, small-group learning, longitudinal learning over two years.*

*The link between clinical placement experiences in nursing to applied philosophy, critical thinking and ethical decision-making.*

*Application of theory in lab/clinical settings in order to enhance knowledge and skills.*

*Students are often in multidisciplinary groups, with a maximum number of 14 students per group.*

These six individuals also provided some of the following responses to indicate what they felt were least successful about their course (a complete listing of responses is available from the CCMHI):

*Curriculum is very intense and often emotionally draining, dealing with complex issues such as family violence and assault.*

*Students don't always like the online portion, because the subject matter is sometimes very abstract and they want to be in the class to talk about it and see each other in the discussion.*

*The most challenging aspect of this course is the heavy assignments for students and faculty.*

*For reasons of scheduling in an intensive program, we've not found ways to incorporate students from a full range of health professional disciplines into these learning experiences.*

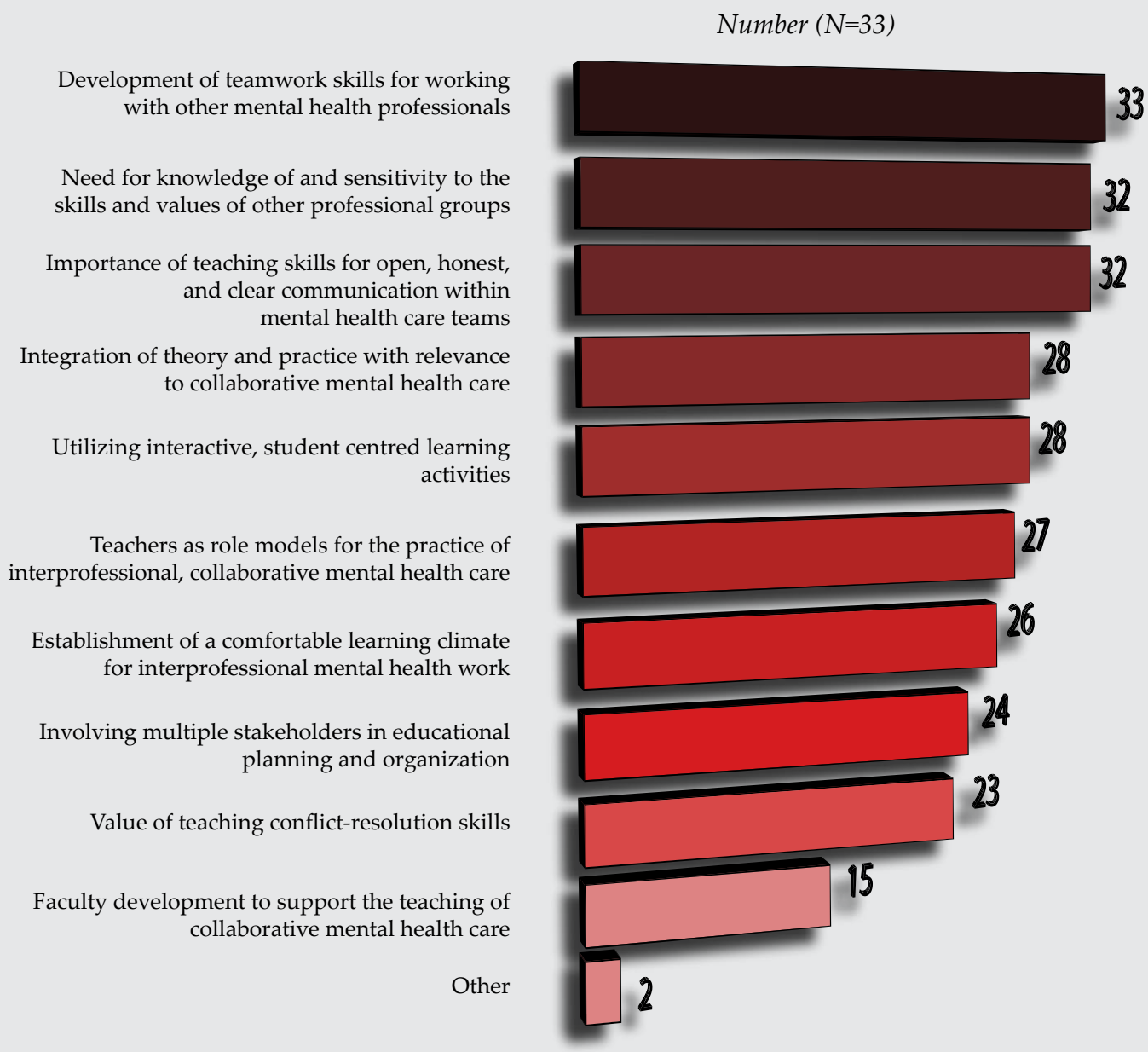
## Teaching goals related to the practice of collaborative mental health care

Respondents who indicated that a) their institutions offered formal courses, workshops, or modules, or b) their programs supported the concept of interprofessional education, were asked to select from a list of teaching goals. These goals were related to how the practice of collaborative mental health care was supported

in the programs. In Figure 2, the goals are ranked in order of frequency of selection.

Respondents felt that the development of communication and teamwork skills; knowledge of and sensitivity to the skills and values of other professionals; and good teaching and learning practices were some of the most important goals supported by their programs. It is interesting to note that enhancing faculty development to support the teaching of collaborative mental health care came up least frequently in the responses.

figure 2 **Teaching goals supported in health education programs (Phase I)**



Respondents also had the option of adding other goals that were not listed in the survey. Two respondents added the following:

*Shared care models in family medicine and psychiatry training programs.*

*We encourage students to attend and participate in interdisciplinary conferences in the clinical setting. Students work within the interdisciplinary team on the unit. Students receive informal instruction (and in some cases, formal instruction) in the clinical setting from other disciplines.*

## Barriers to interprofessional education

Respondents identified problems with scheduling, rigid curriculum, lack of reward for faculty, and lack of financial resources as the most prominent barriers to interprofessional education in their institutions. Turf battles and student/learner acceptance were the lowest-rated barriers. Ratings for lack of administrative support, lack of perceived value, and faculty attitudes were also low. Results are presented below in Table 4, and the highest percentage for each factor is highlighted in bold text.

table 4 **Barriers to interprofessional education (Phase I)**

| **Statement: This factor is a potential barrier to the implementation of interprofessional education for collaborative mental health care ...** | Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Not applicable | Response total |
|---|---|---|---|---|---|---|---|
| Problems with schedule/calendar | 3% | 6% | 17% | **37%** | 34% | 3% | 35 |
| Rigid curriculum | 11% | 23% | 9% | **37%** | 20% | 0% | 35 |
| Lack of reward for faculty | 8% | 19% | 22% | **39%** | 11% | 0% | 36 |
| Lack of financial resources | 3% | 23% | **26%** | 23% | 23% | 3% | 35 |
| Classroom size | 9% | **29%** | 14% | 26% | 17% | 6% | 35 |
| Lack of administrative support | 9% | **40%** | 17% | 20% | 14% | 0% | 35 |
| Lack of perceived value | 27% | **27%** | 18% | 24% | 6% | 0% | 34 |
| Faculty attitudes | 17% | **34%** | 20% | 20% | 9% | 0% | 35 |
| Student/learner acceptance | 26% | **34%** | 11% | 23% | 6% | 0% | 35 |
| Turf battles | 20% | **29%** | 23% | 23% | 9% | 3% | 35 |
| | | | | | | Total number of responses | 36 |
| | | | | | | Skipped this question | 12 |

*Adapted from Dr. S. Gardner, Pharm.D., Ed.D., Department of Pharmacy Practice, University of Arkansas for Medical Sciences*

Some respondents identified a range of other barriers to interprofessional education for collaborative mental health care in their institutions (see Table 5). Some of these barriers included administrative issues and the heavy time demand on students.

## Enablers to interprofessional education

Most of the respondents felt that being open to the ideas of other professional groups was a key enabler to interprofessional education. Support from senior administrators and strong collaborative relationships with faculty from other professions were important factors as well (see Table 6; a complete listing of responses is available from the CCMHI).

table 5 **Other barriers to interprofessional education identified by respondents (Phase I)**

| Category | Examples of responses |
|---|---|
| Curriculum | Differing levels and content knowledge needed by different mental health professionals<br>Curricular focus on physical and psychosocial aspects of health care |
| Time | Heavy time demands on students<br>Timetabling conflicts<br>Limited faculty and teaching hours<br>Lack of time to meet with colleagues to discuss issues.<br>Lack of clinical hours |
| Isolation | Lack of other health disciplines in an institution<br>Distance delivery of courses with fewer opportunities to interact |
| Administration | Co-ordination of courses, labs, faculty, and students, especially where class sizes are large<br>Structures that reinforce disciplinary isolation<br>Campus layout discourages joint classes |
| Attitudes | Complacency<br>Status quo<br>Lack of buy-in for interprofessional education<br>Lack of knowledge about how to incorporate interprofessional education |
| Accreditation and licensing regulations | Limitations on who can supervise students |

table 6 **Key enablers for interprofessional education by category (Phase I)**

| Category | Examples of responses |
|---|---|
| Attitudes | Accepted by different groups<br>Attitudes of faculty in graduate programs related to interprofessional teaching<br>Willingness to work toward this goal<br>Motivation of faculty and students |
| Internal and external support, "champions" | Administrative support<br>A person who works diligently to achieve the goal<br>Supportive and visionary senior administration (i.e., deans, program directors, senior administration in institution as a whole) |
| Collaboration and relationship-building | Contacts with other professionals<br>Developing relationships with faculty from other professional schools<br>Collaboration between faculty members<br>Opportunities for collaboration exist within the clinical institution |
| Clinical placements and service learning | Fieldwork, practicum, and other clinical placements<br>Occupational therapy clinical field work placements provide our occupational therapy students with informal direct observation and participation in interprofessional education experiences such as ward rounds, team meetings, etc |
| Faculty/teaching | Cross-faculty teaching<br>Modelling of interprofessional education for other health care areas<br>Available faculty from other disciplines<br>Cohesive and supportive faculty relations |
| Financial | Financial resources<br>Funds to arrange workshops<br>Funding for pilot projects |
| Research on interprofessional education | Good avenue to discuss interdisciplinary practice rather than just letting it happen during clinical experiences<br>Use of multidisciplinary journals |
| Curriculum | Special workshops not bound by formal curriculum· Existing group dynamics course focuses on team interactions, conflict resolution skills, etc.<br>Curriculum renewal |
| Students | Student assessment activities<br>Enthusiasm of students for interprofessional education<br>Accepted by most learners |
| Requirements of professions | Increasing education level of nurses to match that of other professional groups |
| Administrative | Willingness from multiple groups to be flexible in their scheduling |

# RESULTS FROM PHASE II

**Description of respondents: response rates and breakdown by professional group**

A total of 424 (374 English, 50 French) contacts were invited to participate in the Phase II survey, and 94 (87 English, 7 French) responses were received. The response rate for Phase II was 22.2% (23.3% for the English survey; 14.0% for the French). The majority of respondents for the English survey were from nursing, followed by those from medicine/ family medicine (see Table 7 and Figure 3). The highest response rate in the French survey came from nursing.

table 7 **Response rates and breakdown by professional group (Phase II)**

| Professional Group | Dietetics | Medicine/ family medicine | Nursing | Occupational therapy | Pharmacy | Psychology | Social work | Psychiatric medicine | Consumer | Other | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| English Surveys | | | | | | | | | | | |
| Total | 1 | 62 | 98 | 29 | 23 | 77 | 36 | 10 | 38 | 2 | 376 |
| Number sent successfully✦ | 1 | 61 | 97 | 29 | 23 | 77 | 36 | 10 | 38 | 2 | 374 |
| Number not able to be sent■ | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Number responses | 1 | 18 | 25 | 8 | 7 | 9 | 9 | 4 | 6 | 0 | 87 |
| Per cent total responses (n=34) | 1.1 | 20.7 | 28.7 | 9.2 | 8.0 | 10.3 | 10.3 | 4.6 | 6.9 | 0 | 100 |
| Per cent total contacts for profession | 100 | 29.5 | 25.8 | 27.6 | 30.4 | 11.7 | 25.0 | 40.0 | 15.8 | 0 | 23.3 |
| French Surveys | | | | | | | | | | | |
| Total | 0 | 8 | 11 | 4 | 3 | 9 | 10 | 3 | 2 | 0 | 50 |
| Number sent successfully✦ | 0 | 8 | 11 | 4 | 3 | 9 | 10 | 3 | 2 | 0 | 50 |
| Number not able to be sent■ | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Number responses | 0 | 0 | 6 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 7 |
| Per cent total responses (n=34) | 0 | 0 | 85.7 | 0 | 0 | 0 | 14.3 | 0 | 0 | 0 | 100 |
| Per cent total contacts for profession | 0 | 0 | 54.5 | 0 | 0 | 0 | 10.0 | 0 | 0 | 0 | 14.0 |

✦ *Messages sent without "message undeliverable" responses.*

■ *Messages sent with "message undeliverable" responses and no alternative contact available.*

## Group characteristics

The majority of the respondents to the Phase II survey (50%) were academic programs (see Figure 4). The remaining participants were provincial/territorial professional associations

figure 3 **Percentage of total responses by professional group, Phase II (English)**

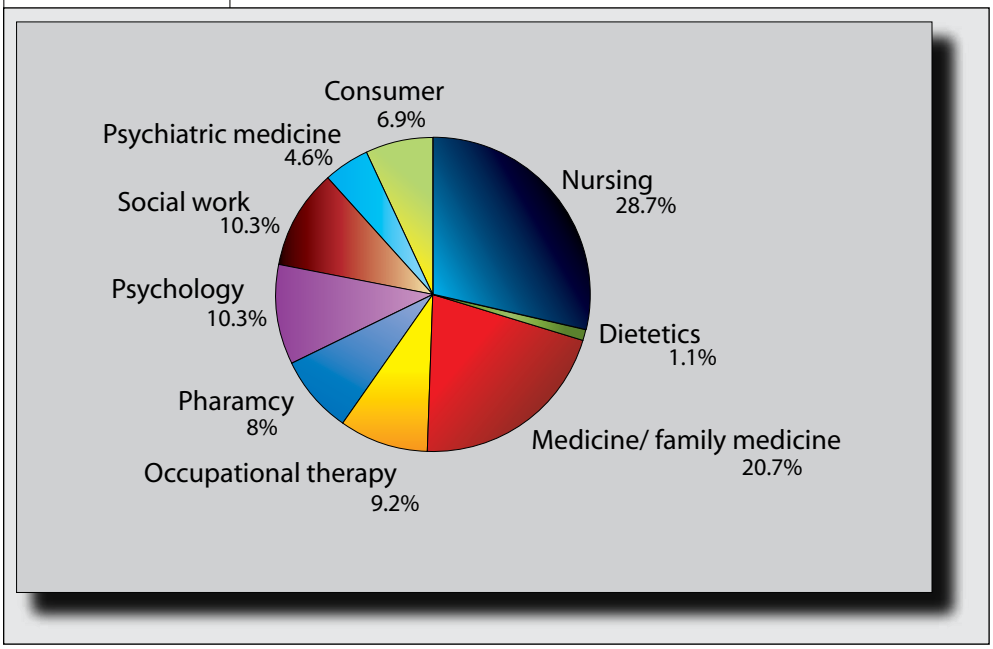



figure 4 **Percentage breakdown of self-identified group description, Phase II (English)**

(22%); community agencies (6%); or one of three other agencies — government, mental health advocacy organization, and national professional association — (5% each). Seven per cent of respondents did not identify their affiliation.

Similar results were found when participants were asked to identify which consumers their group focused on. The majority (71%) indicated that their group did not focus on any particular set of consumers. Child and adolescent mental health was the next most common response at 19%; volunteers were the least represented, at 4%.

Although most respondents (78%) stated that their group did not offer post-licensure or interprofessional education in collaborative mental health care, more than half (64%) indicated that their group had links to other agencies, societies, associations, or institutions that did.

## Current status of post-licensure or continuing interprofessional collaborative mental health care education

The majority of respondents (43.6%) indicated that although their group did not offer post-licensure/continuing interprofessional education, members were encouraged to participate in continuing interprofessional education with a focus on collaborative mental health care (see Table 8).

## Descriptions of programs

Respondents who indicated that their group offered continuing/post-licensure interprofessional education provided a description of these programs (see Appendix G). These groups were located in Kamloops and

table 8 **Current status of interprofessional education for collaborative mental health care (Phase II)**

| Which of the following statements best describes the current status of continuing interprofessional education for your group (organization/ association/institution)? [NB: In the context of this survey, professionals are health experts. Health experts include practitioners, health providers, and consumers.] | % | Total |
|---|---|---|
| Our group offers continuing/post-licensure interprofessional education (courses, workshops, modules) that focuses on collaborative practice/care in the area of mental health | 18.1 | 17 |
| Our group offers continuing/post-licensure interprofessional education (courses, workshops, modules) | 22.3 | 21 |
| Our group guides the provision of interprofessional education, as well as continuing education, by crediting or accrediting these activities | 14.9 | 14 |
| **Our group does not offer continuing/post-licensure interprofessional education (courses, workshops, modules), but we encourage our members to participate in continuing interprofessional education with a focus on collaborative mental health care** | **43.6** | **41** |
| Skipped this question | 1.1 | 1 |

Vancouver, British Columbia; Calgary and Medicine Hat, Alberta; Winnipeg, Manitoba; Hamilton, Kingston, North York, Ottawa, Toronto, Scarborough, and South Porcupine, Ontario; Chicoutimi and Laval, Quebec; and St. John's, Newfoundland.

The professions most commonly cited as leading or instructing the described programs were social workers, nurses, psychologists, psychiatrists, and occupational therapists.

The learners/participants most commonly cited in the described programs were nurses, social workers, caregivers, psychologists, and occupational therapists.

The described programs were wide-ranging in their content. Some offered theoretical instruction on mental health issues and treatment options, as well as educational support and updates on treatment and service delivery. Others offered a specific focus on a particular issue of mental health (e.g., impact of family violence, geriatric care, fetal alcohol syndrome). The rest were designed to prepare learners for professional practice in a particular field. The majority were offered once a year in a university/college setting, and instruction time ranged from eight to 45 hours.

A wide variety of learning activities and methods of assessment/evaluation were described by participants. The most common learning activities included didactic instruction, small-group discussion, and case-based learning. The most common methods of assessment/evaluation included self-assessment, peer-assessment, and attitudinal surveys/questionnaires.

## Helpful and hindering factors to successful programs

Respondents were asked what they felt made the course successful and what factors they felt hindered the course from being more successful. Following are some of the responses regarding what survey participants felt made the course a success (a complete listing of responses is available from the CCMHI):

*Interactive case-based vignette video on CD-ROM highly contextualized to the practice realities and challenges for the primary health care physician learners.*

*Teaching techniques of the educator, the participants, and the information used.*

*Practical-skills teaching, small-group format, tests and assignments, access to instructor.*

*Sharing the difficulties of facilitators, providing a take-home manual for reference, involving everyone's ideas, role-playing difficult group interactions, awareness of facilitator burn-out, preparing for crisis, and knowing how to do successful follow-up with both the involved individuals and all the members present in the group.*

Below are some of the responses regarding what survey participants felt hindered their course from being successful:

*Could use more time and opportunity for learners to practice skills with feedback.*

*Cost.*

*Lack of funding to offer more ongoing workshops.*

*Poor content, presenter who is a poor speaker and does not have experience to pull from. Material is not current or relevant to the target group. Session is mandatory, and attendees are forced to participate — less buy-in by the group.*

## Barriers to interprofessional education

Respondents identified a number of barriers, including a lack of financial resources, a lack of administrative support, and problems with scheduling. Lack of perceived value and faculty/board/member attitudes were the lowest-rated barriers. Results are presented below in Table 9, and the highest percentage for each factor is highlighted in bold text.

These results were similar to those of Phase I (see Table 4), which found that scheduling and financial resources were problematic for developing and maintaining interprofessional education. Faculty attitudes and lack of perceived value were among the lowest-rated barriers in both Phases I and II.

Participants also identified some additional barriers to interprofessional education in their group (see Table 10 for examples; a complete listing is available from the CCMHI). Some of these barriers included accessibility and time constraints, as well as limited resources and a limited knowledge base.

## Enablers to interprofessional education

Respondents identified a number of factors they felt facilitated the integration of various groups into collaborative training arrangements. Some of these factors include the following: ensuring the recognition and respect of all professions, having access to time and resources, and financial support (see Table 11 for examples;

table 9 **Barriers to interprofessional education (Phase II)**

| Statement: This factor is a potential barrier to the implementation of interprofessional learning ... | Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Not applicable | Response total |
|---|---|---|---|---|---|---|---|
| **Problems with schedule/ calendar** | 6% | 15% | 13% | **37%** | 21% | 7% | 67 |
| **Lack of financial resources** | 4% | 9% | 6% | **40%** | 37% | 3% | 67 |
| **Lack of administrative support** | 7% | 16% | 24% | **33%** | 16% | 3% | 67 |
| Lack of perceived value | 16% | **39%** | 10% | 22% | 9% | 3% | 67 |
| Faculty/board/member attitudes | 22% | 22% | **25%** | 13% | 9% | 9% | 67 |
| Turf battles | 15% | 19% | 16% | 18% | **21%** | 10% | 67 |
| | | | | | | Total number of responses | 67 |
| | | | | | | Skipped this question | 27 |

*Adapted from Dr. S. Gardner, Pharm.D., Ed.D., Department of Pharmacy Practice, University of Arkansas for Medical Sciences*

a complete listing of responses is available from the CCMHI).

Respondents also identified a number of key incentives for offering interprofessional education. Some of these incentives include the following: the better delivery of products to consumers, valuing the interconnectedness between different groups, and the ability to transfer knowledge. Financial incentives were another commonly identified factor (see Table 12 for examples; a complete listing of responses is available from the CCMHI).

table 10 **Other barriers to interprofessional education identified by respondents (Phase II)**

| Category | Examples of responses |
|---|---|
| Accessibility and time constraints | Access to the care providers<br>Lack of time<br>Practitioners' time availability<br>Travel concerns in rural areas |
| Limited resources, limited knowledge base | Qualified presenters for education<br>Expertise<br>Ignorance of roles |
| Curriculum constraints | Professional skills specific to psychologists<br>Need to keep up to date in own field<br>Lack of understanding of mental health issues<br>Diversity of scope of practice |
| Financial limitations | Cost of such education to the individual participant, given the high proportion of consumers and family members<br>Government cutbacks and changes to programs<br>Lack of good funding models for interprofessional education |
| Resistance to "buy-in" | Lack of evidence about the benefits<br>Psychiatric nurses have a history of needing to defend their existence as a result of a misperception of registered nurses respecting the value of their work<br>Lack of receptivity in learner group |
| Logistical concerns | Group size<br>Challenge effecting co-ordination with multiple stakeholders when all are busy with variable priorities<br>Promotion and tenure issues for developers |

table 11 **Facilitating factors for collaborative training arrangements (Phase II)**

| Category | Examples of responses |
|---|---|
| Ensuring recognition and respect of all professions | Have a representative from our group and acknowledge our importance<br>Tolerance<br>Respect of others |
| Access to time and resources | Time of training<br>Location<br>Dedicated clinical resources<br>Dedicated administrative support |
| Financial support | Cost<br>Targeted funding for interprofessional education<br>Provincial government support<br>Consistent funding |
| Interprofessional communication and collaboration | Communication between the groups<br>Awareness of what is available<br>Frequently updated lists of contacts |
| Valuing education | Believe in collaborative learning<br>Inter- or transdisciplinary courses<br>General skills and knowledge useful for all professions |
| Leadership support | "Champions" from various sectors involved<br>Other groups taking the lead<br>Infrastructure to support this type of education |
| Research on interprofessional education | Good avenue to discuss interdisciplinary practice rather than just letting it happen during clinical experiences<br>Use of multidisciplinary journals |

table 12 **Key incentives for offering interprofessional education (Phase II)**

| Category | Examples of responses |
|---|---|
| Better delivery of product to customers | Having the practical benefits for one's own clients or practice clearly described<br>To enhance the service delivery of mental health services in our community<br>Offer more co-ordinated and efficient service to clients |
| Valuing interconnectedness | Better understanding of others<br>Team building<br>Networking with others with similar interests<br>Each knows the scope of practice of other groups involved<br>As a group better able to lobby for required services |
| The ability to transfer knowledge | Attaining a broad perspective on mental health<br>Bringing in a speaker who has a strong reputation in the field<br>Embed learning in the regular curriculum<br>Provide time and resources for faculty to immerse them in relevant conceptual and practice knowledge |
| Accreditation/recognition | CME credits<br>University credits toward a degree<br>Accreditation requirements<br>Getting asked to offer it |
| Administrative/bureaucratic requirements | Assurance of public protection<br>Politically correct for annual report<br>Institutional policy |
| Necessity | It is the nature of the work<br>It is the reality of practice today |
| Financial incentives | Professional development fund<br>Affordability<br>Funding staff attendance<br>Financial rewards |
| Improved professional morale/job satisfaction | Recognition for education<br>Decrease isolation of doctors<br>Increase satisfaction of work<br>Professional pride |
| Flexibility | Convenience<br>Accessibility<br>Time to go |

# DISCUSSION

## Response rates

The response rate to questionnaire-survey studies is traditionally lower than for other research methods. A number of strategies to increase response rates were used in this study:

- providing a Web-based survey to make responding more convenient and efficient, and providing a submission deadline
- sending reminder e-mails to potential respondents several weeks after the initial contact
- using existing networks of professional contact through the CCMHI Steering Committee to encourage participation

The main limitation of the survey results relates to the low response rates. In general, the overall participation rate for both phases was 19.7% (see Table 13). For Phase I, which surveyed respondents' knowledge of pre- and post-licensure training, the participation rate was lower than that of Phase II, which surveyed respondents' knowledge of post-licensure or continuing education (15.3% and 22.2%). This may be partly attributed to the fact that Phase I was administered at the end of the summer, while Phase II was administered during the fall/winter seasons. It is also possible that a number of individuals may not have responded because they were not involved with interprofessional education at the time of the survey.

The highest number of responses came from the nursing group (for both the English and French survey). There was also a high response rate from the medicine/family medicine group. It is possible that training courses in collaborative mental health care may be more prevalent in these two professional disciplines and less prevalent in the other disciplines. As a result, professionals working within these disciplines may have been more aware of existing courses.

## Knowledge of existing interprofessional education

Only 25.7% of respondents indicated that learners in their discipline participated in some type of formal interprofessional education. The majority of respondents (54.1%) indicated that no such courses, workshops, or modules existed in their discipline, but that they did encourage teaching philosophies and practices to promote collaborative mental health care.

Oandasan et al's environmental scan found a much higher degree of knowledge among respondents about existing interprofessional educational programs (56%).[2] This scan surveyed a number of successful and unsuccessful interdisciplinary education in health care practice settings and academic institutions. However, the programs included in the scan were not necessarily specific to collaborative mental health care, nor were all respondents from Canada. The results also indicated that the interprofessional education initiatives had taken place equally in both higher education (50%) and service settings (49%). Interprofessional education was reported as occurring in primary health care settings to a much larger extent than in tertiary or rehabilitative care settings. In this survey, most of the programs were offered in higher-education environments (college/university), while others were offered in the community.

table 13 **Combined response rates and breakdown by professional group (Phases I and II)**

| Professional Group | Dietetics | Medicine | Nursing | Occupational therapy | Pharmacy | Psychology | Social work | Family medicine | Psychiatric medicine | Other | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| English Surveys (combined Phase I and II) | | | | | | | | | | | |
| Total | 14 | 89 | 177 | 45 | 30 | 96 | 57 | 23 | 38 | 2 | 571 |
| Number sent successfully✦ | 14 | 88 | 175 | 45 | 30 | 96 | 57 | 23 | 38 | 2 | 568 |
| Number not able to be sent■ | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Number responses | 1 | 25 | 40 | 15 | 8 | 13 | 9 | 4 | 6 | 0 | 121 |
| Per cent total responses (n=34) | 0.8 | 20.7 | 33.1 | 12.4 | 6.6 | 10.7 | 7.4 | 3.3 | 5.0 | 0 | 100 |
| Per cent total contacts for profession | 7.1 | 28.4 | 22.9 | 33.3 | 26.7 | 13.5 | 15.8 | 17.4 | 15.8 | 0 | 21.3 |
| French Surveys (combined Phase I and II) | | | | | | | | | | | |
| Total | 3 | 14 | 20 | 6 | 5 | 17 | 19 | 6 | 2 | 0 | 92 |
| Number sent successfully✦ | 3 | 14 | 20 | 6 | 5 | 17 | 19 | 6 | 2 | 0 | 92 |
| Number not able to be sent■ | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Number responses | 0 | 1 | 6 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 9 |
| Per cent total responses (n=34) | 0 | 11.1 | 66.7 | 0 | 0 | 0 | 22.2 | 0 | 0 | 0 | 100 |
| Per cent total contacts for profession | 0 | 7.1 | 30.0 | 0 | 0 | 0 | 10.5 | 0 | 0 | 0 | 9.8 |

✦ *Messages sent without "message undeliverable" responses.*
■ *Messages sent with "message undeliverable" responses and no alternative contact available.*

### Learning activities

Multiple examples of learning activities were reported in the 34 different courses/ workshops/ modules. The most frequently noted learning activities in both surveys were traditional ones, such as didactic instruction, small-group discussion, and large-group discussion. However, other methods, such as case-based learning, learning activities involving direct service to consumers, role play, and problem-based learning were also often cited by participants.

### Evaluation methods

Self-assessment and objective testing were some of the commonly identified evaluation methods.

### Goals

While all the detailed program descriptions in Phase I referred to goals such as multidisciplinary teamwork, only one included students from more than one profession. However, the majority of programs in Phase II did target many different professional groups.

### Success factors

Respondents to Phases I and II differed in what they thought made their programs successful. In Phase I, respondents felt that bringing theory, ethics, and practice together, as well as providing an opportunity for students to gain exposure to and appreciation for the roles of other professionals contributed to the success of their programs. Phase II respondents emphasized the quality of the instructor, method of instruction, and relevance of the program content to practice.

The elements noted in Phase I that made programs least successful included workload issues and a lack of solid program evaluation. In Phase II, they included lack of funding, scheduling or time difficulties, and poor presentation/content of the program.

The majority of participants in both phases also indicated that the mandate, beliefs and/or mission statements of their program involved the following:

- developing teamwork skills and approaches for working with other health professionals
- integrating theory with practice with regard to collaborative mental health care
- ensuring that service models facilitate a care approach based on a multidimensional health perspective and developing knowledge of and sensitivity to the skills and values of other professional groups working in health care
- emphasizing the importance and teaching the skills for open, honest, and clear communication within interprofessional health teams
- establishing a comfortable open and respectful learning environment for interprofessional health care training and work

## Faculty development

Despite the relative scarcity of formal courses, workshops, and modules among the groups surveyed, teaching goals related to the practice of collaborative mental health care are reported as being supported within their programs. However, there has reportedly been little faculty development to support these goals. Faculty development refers to the broad range of activities institutions use to renew

or assist faculty in their multiple roles. It is necessary to prepare faculty members in their role as facilitators of shared learning. The goal of faculty development is to teach faculty members the skills relevant to their institutional and faculty position.

According to Curran, there has been little reported in the literature related to faculty development and interprofessional education.[3] In this report, Curran notes the importance of training for teachers and tutors who lack experience in this area. The quality of teaching and supervision is of crucial importance to student learning; it is essential for educators to be able to act as role models.

A number of authors have also highlighted the need for faculty development in this area, including the World Health Organization (WHO) Study Group on Multiprofessional Education of Health Personnel.[4] This group acknowledged the relative absence of structured teacher training programs in the area of interprofessional education.

There is a need to provide teachers, in both the clinical and classroom settings, with the knowledge, skills, and attitudes needed to foster interprofessional learning. In particular, faculty development must encompass a focus on attitudinal change, an increased understanding of the roles and responsibilities of other health care professionals, and acquisition of skills in the areas being taught to students. Steinert recommends that faculty development programs include four key aspects: personal development, instructional development, leadership development, and organizational development.[5]

At the individual level, faculty development should do the following:

- address attitudes and beliefs that impede successful interdisciplinary education in collaborative mental health care
- transmit knowledge about interprofessional education, practice and teaching
- develop skills in teaching, curriculum design and interprofessional work

At the organizational level, faculty development should do the following:

- create opportunities for learning together
- empower teams and reward collaborative mental health care initiatives
- address systems issues that can impede interprofessional education

Steinert recommends that faculty-development initiatives should target the following:[6]

- curriculum planners responsible for the design and delivery of interprofessional education programs
- administrators responsible for education and practice; all health care professionals involved in teaching and learning
- organizations in which interprofessional education and collaborative consumer-centred practice occurs

## Barriers

Both Phases I and II provided details on perceived and potential barriers to the implementation of interprofessional education for collaborative mental health care. In Phase I, participants indicated that logistical and administrative barriers were key obstacles, including scheduling, rigid curriculum, lack

of reward for faculty, and lack of financial resources. Barriers related to the attitudes of faculty and students toward interprofessional learning were less commonly reported.

In Phase II, participants pointed to timing, scheduling, financial limitations, lack of administrative/executive support, and logistical problems as key barriers. Faculty/board/member attitudes, lack of perceived value, and turf battles were not indicated as barriers to interprofessional education.

Overall, these findings suggest that barriers were more commonly related to logistical (scheduling, timing, curriculum) and financial issues rather than to indifference or negative attitudes toward interprofessional education.

Similarly, a number of barriers to the successful implementation of interprofessional education have been identified in the literature. Barriers may include the perceived loss of professional and disciplinary status, curricular and scheduling challenges, and lack of familiarity and comfort with interprofessional education among universities and departments.[7] There may also be an a certain level of "unwillingness" on the part of both students and teachers to experiment with new ways of learning and teaching, or with the use of different learning and teaching materials.[8]

Curran conducted a survey of senior administrators of health professional education programs in Canada where respondents were asked to identify perceived barriers.[9] The top four barriers identified by respondents were as follows:

1. problems with schedule/calendar
2. rigid curriculum
3. lack of financial resources
4. lack of perceived value

Respondents were also asked to identify other barriers that they felt impeded interprofessional education efforts. Some of these other barriers included the following:

- lack of resources, interest or time to co-ordinate
- concern over consequences of blending knowledge and diluting professional roles for the future
- accreditation requirements
- inequality of disciplines' status within the health care system
- perceived hierarchy among health disciplines
- domination by one of the other disciplines

Parsell and Bligh have categorized the various barriers to interprofessional education into the following areas:[10]

- Structural:
  - timetabling difficulties
  - requirements of professional bodies (graduation, accreditation)
  - practical difficulties (professional schools located in different buildings)
  - time (for course planners to meet)
  - financial constraints
- Attitudes:
  - lack of senior management support
  - lack of commitment
  - unwillingness to change attitudes
- Curriculum/teaching:
  - curriculum structures and design
  - single subject approach to teaching

- need for new forms of teaching and learning
- training teachers for different roles

- Professional/disciplinary:
  - lack of knowledge and understanding of other professions
  - redrawing of professional boundaries
  - separate professional languages and concepts

## Enablers

Respondents in Phases I and II also identified a number of enabling factors for interprofessional education for collaborative mental health care. The most frequently cited enablers in Phase I were as follows:

- positive attitudes toward interprofessional mental health care and education on the part of faculty, students, administrators, and external partners
- internal and external support ("champions")
- collaboration and relationship-building

Phase II participants stated that key incentives to offering interprofessional education were primarily as follows:

- ensuring recognition and respect of all professions
- providing access to time and resources
- providing financial support

Oandasan et al also identified a number of self-reported enablers that are consistent with the findings of this survey, including the following:[11]

- sound program logistics and administration
- balanced participation from different professional/discipline groups
- programmatic and financial sponsorship
- organizational support
- critical mass of learners
- participant compensation
- quality improvement paradigm

# CONCLUSION

The findings from this survey suggest that the majority of educational institutions and professional groups across Canada do not offer formal interprofessional education for collaborative mental health care. This may be due to a number of factors, including logistical and administrative concerns (scheduling, rigid curriculum), lack of reward for faculty, lack of financial resources, and a lack of executive support.

There are some key enablers that may promote the development of interprofessional education. Having a positive attitude toward interprofessional mental health care and education on the part of all of the key players (faculty, students, administrators, and partners) is one enabler. Encouraging collaboration and relationship-building among these players is another, as well as ensuring the recognition and respect of all professions.

The majority of the survey respondents supported the development of interprofessional bridges with other mental health professionals. They also acknowledged the need for awareness of and sensitivity to the skills and values of other professional groups. The importance of teaching skills for open, honest, and clear communication within mental health care teams was also mentioned, as well as valuing of the skills and approaches that other disciplines bring to mental health care.

Some key recommendations include the following:

- fostering co-operation and collaboration among faculty members, senior administrators, and other key players within existing institutions to support the development of interprofessional education in collaborative mental health care
- addressing logistical barriers, such as rigid curriculum and scheduling concerns, to make interprofessional courses more accessible
- allocating more funding to create and sustain interprofessional education, as well as to reward faculty members responsible for the programs

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# appendixA

# GLOSSARY OF TERMS & ACRONYMS

## Terms

| | |
|---|---|
| COLLABORATIVE CARE/ COLLABORATIVE PRACTICE | An interprofessional process of communication and decision-making that allows the knowledge and skills of different health care providers, along with the client/consumer, to influence the care provided to that consumer.[12] Collaborative practice involves patient-centred care with a minimum of two caregivers from different disciplines working together with the care recipient to meet the assessed health care needs.[13] |
| COLLABORATIVE MENTAL HEALTH CARE | Collaborative care for the purposes of enhancing mental health outcomes. |
| DIDACTIC INSTRUCTION | Involving lecture and textbook instruction rather than demonstration and laboratory study. |
| GROUP | An organization, association, or institution. |
| HEALTH CARE PARTNERS | Primary and mental health care providers, consumers, families and caregivers. |
| INTERPROFESSIONAL EDUCATION | Occasions when two or more professions learn from and about each other to improve collaboration and the quality of care. |
| POST-LICENSURE LEVEL | Continuing education for health care professionals. |
| PRE-LICENSURE LEVEL | Undergraduate- and graduate-level training. |

| | |
|---|---|
| PRIMARY HEALTH CARE | An individual's first contact with the health system characterized by a spectrum of comprehensive, co-ordinated and continuous health care services such as health promotion, diagnosis, treatment, and chronic disease management.[14] |
| PRIMARY HEALTH CARE SETTING | Primary health care is delivered in many settings such as the workplace, schools, home, health-care institutions, homes for the aged, nursing homes, day-care centres, offices of health care providers, and community clinics. It is also available by telephone, health information services and the Internet.[15] |

## Acronyms

| | |
|---|---|
| **CCMHI** | Canadian Collaborative Mental Health Initiative |
| **CCHPE** | Centre for Collaborative Health Professional Education |
| **CME** | Continuing medical education |
| **WHO** | World Health Organization |

# appendixB

## SURVEY FORM (Phase I)

Interprofessional Education Initiatives in Collaborative Mental Health Care
Canadian Collaborative Mental Health Initiative

The Canadian Collaborative Mental Health Initiative has commissioned our team to conduct a survey to review current education/training in collaborative mental health care approaches in Canadian universities/colleges.

As an academic administrator of a health professional education program, your feedback on collaborative mental health care education/training opportunities in your institution is very important.

The following survey has been designed to gather information about the current state of collaborative mental health care education/training in Canada. It should take no more than 10–15 minutes to complete.

Some key definitions are:

Interprofessional Education
"occasions when two or more professions learn from and about each other to improve collaboration and the quality of care" (CAIPE, 1997 revised)

Collaboration
"an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided" (Way & Jones 2000)

Interprofessional Healthcare Team
"medical and health professionals from at least three different disciplines or professions, who share a common purpose and work together collaboratively and interdependently to serve a specific patient/client population and achieve the team's and organization's goals and objectives" (Curran, 2004)

Pre-Licensure Education
an educational activity that involves students at the undergraduate or post-graduate levels of training before qualification or licensure has been obtained to practice independently.

Post-Licensure Education
an educational activity that involves health and/or social care practitioners who are qualified or licensed to practice independently.

If you have any questions about the survey or difficulties in completing it, please contact:

Diana R. Deacon
Health Professional Education Specialist
Phone: (709) 777-7077
e-mail: ddeacon@mun.ca

Dr. Vernon Curran
Director, Research and Development
Phone: (709) 777-7542
e-mail: vcurran@mun.ca

Centre for Collaborative Health Professional Education
Faculty of Medicine
Memorial University of Newfoundland
Fax: (709) 777-6576

Which of the following statements best describes the current status of interprofessional education for collaborative mental health care in your institution and for your discipline?

- ☐ Students/learners in our discipline participate in some type of formal interprofessional education course/workshop/module that has focused on collaborative mental health care. *(Please complete Sections 1, 2 and 3.)*
- ☐ No formal interprofessional courses/workshops/modules for collaborative mental health care exist for our discipline, but teaching philosophies and practices that promote collaborative mental health care are encouraged. *(Please complete Sections 2 and 3.)*
- ☐ Our discipline does not currently offer formal courses/workshops/modules or promote teaching philosophies/practices that encourage collaborative mental health care. ***(Please complete Section 3.)***

Section 1. Formal courses/workshops/modules for collaborative mental health care at pre-licensure and/or post-licensure education levels.

Please describe the characteristics of interprofessional education for collaborative mental health care courses/workshops/modules at your institution at the pre-licensure and/or post-licensure education levels. If more than one course/workshop/module exists at either of these levels, *please complete a separate entry to describe each initiative.*

*Courses/workshops/modules*

**1. What is the name of the course/workshop/module?** _____

**2. What is the main goal/purpose of the course/workshop/module? Please describe.** _____

_____

_____

_____

_____

_____

3. Where does this course/workshop/module take place? _____

Please provide the name of the institution _____

4. What level are the learners in this course/workshop/module?

- ☐ Pre-licensure (e.g., undergraduate/post-graduate students)
- ☐ Post-licensure (e.g., licensed health practitioners)

5. Is it in a:

- ☐ Higher education institution
- ☐ Service setting (clinical setting)
- ☐ Mixed (a clinical setting with higher education links or vice versa)

6. If in a service setting or mixed setting, is it:

- ☐ Primary ambulatory care
- ☐ Community-based care
- ☐ Tertiary care
- ☐ Other (please specify): _____

7. Who are the students/learners? (professional/discipline affiliations) (check all that apply)

- ☐ Nutrition/dietetics
- ☐ Medicine
- ☐ Nursing
- ☐ Occupational therapy
- ☐ Pharmacy
- ☐ Psychology
- ☐ Social work
- ☐ Other (please specify) _____
- ☐ Other (please specify) _____
- ☐ Other (please specify) _____

8. What is the length of the course/workshop/module?

Days _____Weeks _____OR Months _____

How many hours in total? _____

9. Which of the following learning/assessment activities are included in the course/workshop/module? (check all that apply):

*Learning activities*

- ☐ Didactic instruction (e.g., lecture/presentations)
- ☐ Panel discussion
- ☐ Case-based learning
- ☐ Problem-based learning
- ☐ Large group discussion
- ☐ Small group discussion
- ☐ Role playing
- ☐ Standardized patients/clients
- ☐ Clinical learning experience (e.g., internship, practicum, traineeship)
- ☐ Learning activities involving direct service to clients/patients
- ☐ Other (please specify) _____
- ☐ Other (please specify) _____
- ☐ Other (please specify) _____

*Assessment activities*

- ☐ Self-assessment
- ☐ Peer-assessment
- ☐ Objective testing (e.g., multiple-choice question tests and/or test banks)
- ☐ Attitudinal surveys/questionnaires
- ☐ Learning portfolio
- ☐ Personal learning diary
- ☐ Essay/report
- ☐ Group project (e.g., report, presentation)

- ☐ Role play
- ☐ Standardized patient/client
- ☐ Objective Structured Clinical Examination (OSCE)
- ☐ Group Objective Structured Clinical Examination (GOSCE)
- ☐ Review of videotapes or audiotapes
- ☐ Other (please specify) _____
- ☐ Other (please specify) _____
- ☐ Other (please specify) _____

**10. What is most successful about the course/workshop/module?**

_____
_____
_____
_____
_____

**11. What is least successful about the course/workshop/module?**

_____
_____
_____
_____

**Section 2: Teaching goals and practices that promote collaborative mental health care learning**

**12. Which of the following teaching goals related to the practice of collaborative mental health care are supported within your programs? (check all that apply):**

- ☐ Need for knowledge of, and sensitivity to, the skills and values of other professional groups
- ☐ Development of teamwork skills for working with other mental health professionals
- ☐ Importance of teaching skills for open, honest and clear communication within mental health care teams
- ☐ Value of teaching conflict resolution skills
- ☐ Teachers as role-models for the practice of interprofessional, collaborative mental health care
- ☐ Integration of theory and practice with relevance to collaborative mental health care
- ☐ Involving multiple stakeholders in educational planning and organization
- ☐ Establishment of a comfortable learning climate for interprofessional mental health work
- ☐ Utilizing interactive, student-centered learning activities
- ☐ Faculty development to support the teaching of collaborative mental health care
- ☐ Other (please specify) _____
- ☐ Other (please specify) _____
- ☐ Other (please specify) _____

**13. The factors below have been identified as potential barriers to the implementation of interprofessional education. To what extent do you believe that each of the following factors serves as a barrier to interprofessional education for collaborative mental health care at your institution?**

Please indicate your level of agreement with each of the following statements, by checking the appropriate space following each statement.
Use the scale SD = strongly disagree; D = disagree; N = neutral; A = agree; SA = strongly agree; NA = not applicable

| STATEMENT: This factor is a potential barrier to the implementation of interprofessional learning for collaborative mental health care… | SD | D | N | A | SA | NA |
|---|---|---|---|---|---|---|
| Lack of financial resources | | | | | | |
| Lack of administrative support | | | | | | |
| Lack of perceived value | | | | | | |
| Problems with schedule/calendar | | | | | | |
| Classroom size | | | | | | |
| Faculty attitudes | | | | | | |
| Student/learner acceptance | | | | | | |
| Rigid curriculum | | | | | | |
| Turf battles | | | | | | |
| Lack of reward for faculty | | | | | | |

Adapted from Dr. S. Gardner, Pharm.D., Ed.D., Department of Pharmacy Practice, University of Arkansas for Medical Sciences

List any other barriers that you feel limit interprofessional education for collaborative mental health care at your institution.

1. _____

2. _____

3. _____

4. _____

14. What are key enablers to fostering and promoting interprofessional education for collaborative mental health care at your institution?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Section 3: Background Information

15. What type(s) of programs are you responsible for? (check all that apply):

- ☐ Nutrition/dietetics
- ☐ Medicine
- ☐ Nursing
- ☐ Occupational therapy
- ☐ Pharmacy
- ☐ Psychology
- ☐ Social work
- ☐ Other (please specify) _____
- ☐ Other (please specify) _____
- ☐ Other (please specify) _____

*Thank you for completing this survey.*

# appendixC

## SURVEY FORM (Phase II)

Interprofessional Education Initiatives in Collaborative Mental Health Care
Canadian Collaborative Mental Health Initiative

The Canadian Collaborative Mental Health Initiative has commissioned our team to conduct a survey to review how health care professionals are educated and trained to work in collaborative or interprofessional practice in the area of mental health. To gather this information, we are sending the following survey to:

- University and colleges
- National and provincial/territorial professional associations
- National and provincial/territorial regulatory associations
- Mental health advocacy societies and associations

As an organization that guides or provides educational supports to individuals working in the health sector, your feedback on the education and training opportunities you provide, specifically in the area of collaborative mental health care is very important.

The following survey has been designed to gather information about the current state of collaborative mental health care education and training in Canada. The intent is to be inclusive of collaborative training situations and programs involving both professional and community, volunteer and consumer based services.

It should take no more than 10–15 minutes to complete.

Some key definitions are:

Professional:
In the context of this survey, professionals are health experts. Health experts include practitioners, health providers, and consumers.

Interprofessional Education
"occasions where two or more professions learn from and about each other to improve collaboration and the quality of care" (CAIPE, 1997 revised).

Collaboration
"an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided" (Way & Jones, 2000).

Group
For the purpose of this survey, the word "group" is used interchangeably with "organization/association/program/institution."

Post-Licensure Education
Educational activity that has been completed by practitioners who are qualified and licensed to practice independently

Continuing Professional Education
An educational activity that involves on-going education and training of health care professionals.

If you have any questions about the survey or difficulties in completing it, please contact:

Dr. Jonathan McVicar
Project Coordinator
Phone: (709) 737-3501
E-mail: jdm@interchange.ubc.ca

Centre for Collaborative Health Professional Education
Faculty of Medicine
Memorial University of Newfoundland
Fax: (709) 777-6576

Please complete the following questions for your group (organization/association/institution). [NB For the purpose of this survey, professionals are health experts. Health experts include practitioners, health providers, and consumers.]

**a. Which category best describes your group?**

- ☐ Academic program
- ☐ Government
- ☐ Community agency
- ☐ Mental health advocacy organization
- ☐ National professional association
- ☐ Provincial/territorial professional association

**b. Please specify which professional groups make up the membership of your group (check all that apply):**

- ☐ Nurses
- ☐ Social workers
- ☐ Family physicians
- ☐ Psychiatrists
- ☐ Psychologists
- ☐ Dietitians
- ☐ Pharmacists
- ☐ Occupational therapists
- ☐ Consumers
- ☐ Caregivers
- ☐ Volunteers
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____

**c. Please specify the sector in which your group works (check all that apply).**

- ☐ Education
- ☐ Social welfare
- ☐ Community health
- ☐ Recreation
- ☐ Other (please specify): _____

**d. Does your group's work focus on a particular condition? (check all that apply)**

- ☐ Our group does not focus on a particular condition
- ☐ Mood disorders (depression, bipolar)
- ☐ Anxiety disorders
- ☐ Alzheimer's
- ☐ Schizophrenia
- ☐ Addictions
- ☐ Eating disorders
- ☐ Trauma
- ☐ Autism
- ☐ Suicide
- ☐ Other (please specify): _____

**e. Does your group's work focus on serving a particular client group? (check all that apply)**

- ☐ Our group does not focus on a particular client group
- ☐ Senior/geriatric mental health
- ☐ Child and adolescent mental health
- ☐ Aboriginal/First Nations
- ☐ Women
- ☐ New immigrants
- ☐ Caregivers
- ☐ Volunteers
- ☐ Consumers
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____

**f. Does your group have links with other groups that offer continuing interprofessional education with a focus on collaborative mental health care?**

- ☐ Yes
- ☐ No

**If yes, does the other organization represent a different constituency than yours (e.g., a community agency partnering with a professional association, one national professional association partnering with a different national professional association)?**

- ☐ Yes
- ☐ No

**If yes, please specify:**

_____

_____

_____

_____

**g. Which of the following statements best describes the current status of continuing interprofessional education for your group (organization/association/institution)? (check all that apply) [NB In the context of this survey, professionals are health experts. Health experts include practitioners, health providers, and consumers.]**

- ☐ Our group offers continuing/post-licensure interprofessional education (courses, workshops, modules) that focuses on collaborative practice/care in the area of mental health.
- ☐ Our group offers continuing/post-licensure interprofessional education (courses, workshops, modules)
- ☐ Our group guides the provision of interprofessional education, as well as continuing education, by crediting or accrediting these activities
- ☐ Our group does not offer continuing/post-licensure interprofessional education (courses, workshops or modules), but we encourage our members to participate in continuing interprofessional education with a focus on collaborative mental health care.

**Section 1. Courses, workshops or modules with a focus on collaborative mental health care**

Please describe the characteristics of the **interprofessional education for courses/workshops/modules** provided by your group (organization/association/institution) at the post-licensure or continuing professional education level. If more than one course/workshop/module exists at this level, ***please complete a separate entry to describe each initiative.*** [**NB In the context of this survey, professionals are health experts. Health experts include practitioners, health providers, and consumers**.]

**1. What is the name of the course/workshop/module?**

_____

**2. What is the main goal of the course/workshop/module? Please describe the course/workshop/module and include learning objectives.**

_____

_____

_____

_____

_____

**3. How often is this course/workshop/module offered? What is its duration?**

*Frequency*:

- ☐ Once only

_____ times a

- ☐ Week
- ☐ Month
- ☐ Year

Number of hours in total: _____

**4. In what location is this course/workshop/module offered (town/city and province)? In what type of setting (e.g., hospital, university, hotel)?**

Town/city and province: _____

Type of setting:

- ☐ Hospital
- ☐ University/college
- ☐ Community agency/centre
- ☐ Hotel/conference setting
- ☐ Other: _____
- ☐ Other: _____

**5. Who is the target audience for this course/workshop/module? (check all that apply)**

- ☐ Consumers
- ☐ Caregivers
- ☐ Volunteers
- ☐ Community members
- ☐ Managers
- ☐ Coordinators
- ☐ Directors/Executive level
- ☐ Academics
- ☐ Health care providers/practitioners

**6. What materials are used in the delivery of the course/workshop/module? (check all that apply)**

- ☐ Textbooks
- ☐ Workbooks
- ☐ Videos
- ☐ Handouts
- ☐ Articles
- ☐ PDA-based tools
- ☐ Web-based tools
- ☐ Video conferencing
- ☐ Other technology (please specify): _____
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____

**7. What teaching style is employed in the delivery of the course/workshop/module? (check all that apply)**

- ☐ Didactic instruction (e.g., lectures, presentations)
- ☐ Panel discussion
- ☐ Case-based learning
- ☐ Problem-based learning
- ☐ Large-group discussion
- ☐ Small-group discussion
- ☐ Role playing/behavioural rehearsal
- ☐ Standardized patients/clients
- ☐ Learning activities involving direct service to clients/patients
- ☐ Web-based exercises
- ☐ Other (please specify): _____

**8. Who teaches/instructs/leads the course/module/workshop? (check all that apply)**

- ☐ Consumers
- ☐ Caregivers
- ☐ Volunteers
- ☐ Nurses
- ☐ Social workers
- ☐ Family physicians
- ☐ Psychiatrists
- ☐ Psychologists
- ☐ Dietitians
- ☐ Pharmacists
- ☐ Occupational therapists
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____

**9. Who are the learners/participants in the course/module/workshop? (check all that apply)**

- ☐ Consumers
- ☐ Caregivers
- ☐ Volunteers
- ☐ Nurses
- ☐ Social workers
- ☐ Family physicians
- ☐ Psychiatrists
- ☐ Psychologists
- ☐ Dietitians
- ☐ Pharmacists
- ☐ Occupational therapists
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____

**10. How is the course evaluated/assessed?**

- ☐ Self-assessment
- ☐ Peer assessment
- ☐ Objective testing (e.g., multiple choice question tests and/or test blanks)
- ☐ Attitudinal surveys/questionnaires
- ☐ Learning portfolio
- ☐ Personal learning diary
- ☐ Essay/report
- ☐ Group project
- ☐ Role play
- ☐ Standardized patient/client
- ☐ Review of video/audiotapes
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____

**11. What, if any, follow-up do you conduct after the course/module/workshop has been completed? (check all that apply)**

- ☐ Newsletter
- ☐ E-mail reminders and updates
- ☐ Phone calls
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____

**12. What makes the course/workshop/module most successful?**

_____

_____

_____

_____

**13. What factors hinder the course/workshop/module from being more successful?**

_____

_____

_____

_____

**14. Is your program/course/workshop/module accredited for CME/CPD/CE credits?**

- ☐ Yes
- ☐ No

**15. Are you able to share details of your program/course/workshop/module?**

- ☐ Yes
- ☐ No

**If yes, please provide follow-up contact information:**

_____

_____

**16. Do you have another program/course/workshop/module to describe?**

- ☐ Yes
- ☐ No

**Section 2: Group (organizational/association/institutional) goals and beliefs that encourage collaborative learning. [NB In the context of this survey, professionals are health experts. Health experts include practitioners, health providers, and consumers.]**

**17. Which of the following goals match the mandate/mission statement/beliefs of your group regarding collaborative learning? (check all that apply):**

- ☐ To ensure that service models facilitate a care approach based on a multi-dimensional health perspective
- ☐ To develop knowledge of, and sensitivity to, the skills and values of other professional groups working in health care
- ☐ To develop teamwork skills and approaches for working with other health professionals
- ☐ To emphasize the importance of open, honest and clear communication within interprofessional health teams
- ☐ To emphasize the importance of developing conflict resolution skills
- ☐ To integrate theory with practice with regard to collaborative health care
- ☐ To involve multiple stakeholders in developing educational programs involving health care
- ☐ To establish a comfortable, open and respectful learning environment for interprofessional health care training and work
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____

**18. Through what means does your group promote either post-licensure or continuing health care learning apart from offering courses/workshops/modules? (check all that apply)**

- ☐ Required for continuing education credits
- ☐ Required for registration/licensure/membership renewal
- ☐ Embedded in professional ethical code of conduct
- ☐ Encouraged to facilitate adaptation to changing job requirements
- ☐ Other (please specify): _____
- ☐ Other (please specify): _____

**19. The factors below have been identified as potential barriers to the implementation of interprofessional education. To what extent do you believe that each of the following factors serves as a barrier to interprofessional education for collaborative mental health care in your organization/association/institution?**

**Please indicate your level of agreement with each of the following statements by checking the appropriate space following each statement. Use the scale SD = Strongly Disagree; D = Disagree; N = Neutral; A = Agree; SA = Strongly Agree; NA = Not applicable.**

| **STATEMENT: This factor is a barrier to the implementation of interprofessional learning ….** | SD | D | N | A | SA | NA |
|---|---|---|---|---|---|---|
| Lack of financial resources | | | | | | |
| Lack of administrative/executive support | | | | | | |
| Lack of perceived value | | | | | | |
| Problems with schedule/calendar | | | | | | |
| Faculty/Board/Member attitudes | | | | | | |
| Turf battles | | | | | | |

Adapted from Dr. S. Gardner, Pharm.D., Ed.D., Department of Pharmacy Practice, University of Arkansas for Medical Sciences.

**20. List any other barriers that you feel limit interprofessional education in your group:**

a. _____
b. _____
c. _____
d. _____

**21. In the experience of your group, what factors would facilitate opportunities for integration of community agency, volunteer, consumer and other professional groups into collaborative training arrangements?**

a. _____
b. _____
c. _____
d. _____

**22. Based on the experiences of your group, what are key *incentives* to offering interprofessional education?**

a. _____

b. _____

c. _____

d. _____

e. _____

f. _____

g. _____

h. _____

# appendixD

# INVITATION AND REMINDER TO COMPLETE SURVEY (Phase I)

**Invitation to complete survey e-mail text**

Dear Colleagues –

We are looking for your assistance in an initiative to strengthen collaborative, interprofessional mental health care in Canada.

Funded through the Primary Health Care Transition Fund Project (Health Canada), the Canadian Collaborative Mental Health Initiative is comprised of twelve national organizations, representing community services, consumer, family and self-help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers from across Canada. The CCMHI is working to improve the mental health and well-being of Canadians by strengthening the relationships and improving collaboration among health care providers, consumers and their families and communities. For more information, please see http://www.ccmhi.ca.

Our shared vision is of a country where consumers receive the most appropriate service, from the most appropriate provider, when they need it, in a location that is accessible and with the fewest obstacles.

As part of this initiative, the CCMHI has commissioned the Centre for Collaborative Health Professional Education at Memorial University to conduct a survey of health professional education administrators to review the current state of education and training in collaborative mental health care approaches. As an academic administrator of a health professional education program, your feedback is very important. We invite you to participate.

We have constructed an easily accessible, short online survey on attitudes and opinions of interprofessional learning and collaborative patient-centred practice. It should take no more than 10-15 minutes of your time to complete. Please feel free to forward this invitation to another contact in your institution if their feedback would be useful. **Please complete the survey on or before August 30, 2004.**

You can link to the survey at: http://www.surveymonkey.com/s.asp?u=78609588847. If you have any questions or comments regarding the survey, please either e-mail or call Diana R. Deacon, Health Professional Education Specialist, ddeacon@mun.ca or (709) 777-7077.

Thank you in advance for your participation.

Sincerely,

Vernon Curran, PhD
Director, Research and Development
Centre for Collaborative Health Professional Education
Faculty of Medicine
Memorial University of Newfoundland

Peter Cornish, PhD
Registered Psychologist
Director, Counselling Centre
Memorial University of Newfoundland

## Reminder to complete survey e-mail text

**Important notice: Extended deadline for survey responses**

Dear Colleagues –

If you have already responded to the survey, please disregard this reminder notice and thank you for your response. If not, we encourage you to complete the survey as soon as possible. Your feedback is vital to the initiative. Please note that the survey deals with programs at pre- and post-licensure levels (undergraduate, post-graduate, and graduate programs).

We are looking for your assistance in an initiative to strengthen collaborative, interprofessional mental health care in Canada.

Funded through the Primary Health Care Transition Fund Project (Health Canada), the Canadian Collaborative Mental Health Initiative (CCMHI) is comprised of twelve national organizations, representing community services, consumer, family and self-help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers from across Canada. The Initiative is working together to improve the mental health and well-being of Canadians by strengthening the relationships and improving collaboration among health care providers, consumers and their families and communities. For more information, please see http://www.ccmhi.ca.

Our shared vision is of a country where consumers receive the most appropriate service, from the most appropriate provider, when they need it, in a location that is accessible and with the fewest obstacles.

As part of this initiative, the CCMHI has commissioned the Centre for Collaborative Health Professional Education at Memorial University to conduct a survey of health professional education administrators to review the current state of education and training in collaborative mental health care approaches. As an academic administrator of a health professional education program, your feedback is very important. We invite you to participate.

We have constructed an easily accessible, short online survey on attitudes and opinions of interprofessional learning and collaborative patient-centred practice. It should take no more than 10-15 minutes of your time to complete. **Please complete the survey as soon as possible within the next week**. If you are out of the office or otherwise unable to complete the survey within this time, you may respond to the survey at any time before September 24, 2004. Please feel free to forward this invitation to another contact in your institution if their feedback would be useful.

You can link to the survey at: http://www.surveymonkey.com/s.asp?u=78609588847

If you have any questions or comments regarding the survey, please either e-mail or call Diana R. Deacon, Health Professional Education Specialist, ddeacon@mun.ca or (709) 777-7077.

Thank you in advance for your participation.

Sincerely,

Vernon Curran, PhD
Director, Research and Development
Centre for Collaborative Health Professional Education
Faculty of Medicine
Memorial University of Newfoundland

Peter Cornish, PhD
Registered Psychologist
Director, Counselling Centre
Memorial University of Newfoundland

# appendixE

# INVITATION AND REMINDER TO COMPLETE SURVEY (Phase II)

**Invitation to complete survey e-mail text**

Dear Colleagues –

We are looking for your assistance in an initiative to strengthen collaborative, interprofessional mental health care in Canada.

Funded through the Primary Health Care Transition Fund Project (Health Canada), the Canadian Collaborative Mental Health Initiative (CCMHI) is comprised of twelve national organizations, representing community services, consumer, family and self-help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers from across Canada. The CCMHI is working to improve the mental health and well-being of Canadians by strengthening the relationships and improving collaboration among health care providers, consumers and their families and communities. For more information, please see http://www.ccmhi.ca (we also have a French Web site: http://www.iccsm.ca ).

Our shared vision is of a country where consumers receive the most appropriate service, from the most appropriate provider, when they need it, in a location that is accessible and with the fewest obstacles.

As part of this initiative, the CCMHI has commissioned the Centre for Collaborative Health Professional Education at Memorial University to conduct a survey of universities, national and provincial professional and regulatory associations, and mental health advocacy societies and associations to review the current state of collaborative mental health care approaches in post-licensure and continuing education . As a member of an organization that directly or indirectly provides services to individuals with mental health concerns, your feedback on collaborative mental health care education/training opportunities within your program/association is very important. We invite you to participate.

We have constructed an easily accessible, short online survey on attitudes and opinions of interprofessional learning. It should take no more than 10-15 minutes of your time to complete. Please feel free to forward this invitation to another contact in your institution if their feedback would be useful. **Please complete the survey on or before January 7, 2005**.

You can link to the survey at: [original survey link was identified here]

If you have any questions or comments regarding the survey, please either e-mail or call Dr. Jonathan McVicar, jdm@interchange.ubc.ca or (709) 737-3501.

Thank you in advance for your participation.

Sincerely,

Vernon Curran, PhD
Director, Research and Development
Centre for Collaborative Health Professional Education
Faculty of Medicine
Memorial University of Newfoundland

Peter Cornish, PhD
Registered Psychologist
Director, Counselling Centre
Memorial University of Newfoundland

## Reminder to complete survey e-mail text

**Important notice: Extended deadline for survey responses**

Dear Colleagues –

If you have already responded to the survey, please disregard this reminder notice and thank you for your response. If not, we encourage you to complete the survey as soon as possible. Your feedback is vital to the initiative.

We are looking for your assistance in an initiative to strengthen collaborative, interprofessional mental health care in Canada.

Funded through the Primary Health Care Transition Fund Project (Health Canada), the Canadian Collaborative Mental Health Initiative (CCMHI) is comprised of twelve national organizations, representing community services, consumer, family and self-help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers from across Canada. The Initiative is working together to improve the mental health and well-being of Canadians by strengthening the relationships and improving collaboration among health care providers, consumers and their families and communities. For more information, please see http://www.ccmhi.ca.

Our shared vision is of a country where consumers receive the most appropriate service, from the most appropriate provider, when they need it, in a location that is accessible and with the fewest obstacles.

As part of this initiative, the CCMHI has commissioned the Centre for Collaborative Health Professional Education at Memorial University to conduct a survey of universities, national and provincial professional and regulatory associations, and mental health advocacy societies and associations to review the current state of post-licensure education and training in collaborative mental health care approaches. As a member of an organization that directly or indirectly provides services individuals with mental health concerns, your feedback on collaborative mental health care education/training opportunities within your program/association is very important.
We invite you to participate.

We have constructed an easily accessible, short online survey on attitudes and opinions of interprofessional learning and collaborative patient-centred practice. It should take no more than 10-15 minutes of your time to complete. **Please complete the survey as soon as possible within the next week**. If you are out of the office or otherwise unable to complete the survey within this time, you may respond to the survey at any time before January 23, 2005. Please feel free to forward this invitation to another contact in your institution if their feedback would be useful.

You can link to the survey at: [original survey link was identified here]

If you have any questions or comments regarding the survey, please either e-mail or call Dr. Jonathan McVicar, jdm@interchange.ubc.ca or (709) 737–3501.
Thank you in advance for your participation.

Sincerely,

Vernon Curran, PhD
Director, Research and Development
Centre for Collaborative Health Professional Education
Faculty of Medicine
Memorial University of Newfoundland

Peter Cornish, PhD
Registered Psychologist
Director, Counselling Centre
Memorial University of Newfoundland

# appendixF

## PROGRAM DESCRIPTIONS BY INSTITUTION (Phase I)

| Institution | Name of course/ workshop/ module | Goal/purpose | Level of learners/ students | Setting | |
|---|---|---|---|---|---|
| Kwantlen University College<br>Surrey, British Columbia<br>Faculty of Community and Health Studies | Bioethics | Philosophy course that introduces students to core concepts of philosophy and goes on to ethics and ethical decision-making theory. Uses case studies from health and mental health | Both pre- and post-licensure<br>Nursing | Higher-education institution | |
| McMaster University<br>Hamilton, Ontario<br>Faculty of Medicine | Behavioural Science | Two-year course in behavioural sciences for family medicine residents at McMaster University. Residents must meet for half a day per week for the entire two years of their residency | Pre-licensure (e.g., undergraduate/ post-graduate students)<br>Medicine | Mixed higher-education and primary ambulatory care service settings | |
| McMaster University<br>(as above) | Psychiatry for Family Physicians | CME course for family physicians in the community. Teaches them about psychiatric illnesses in a practical manner so as to increase their skills in this area. We meet once per month for ten months | Post-licensure (e.g., licensed health practitioners)<br>Medicine | Higher-education institution | |

| | Length | Learning activities | Assessment activities |
|---|---|---|---|
| | 15 weeks (about 50 hours) | Didactic instruction (e.g., lecture/ presentations)<br>Panel discussion<br>Case-based learning<br>Problem-based learning<br>Large-group discussion<br>Small-group discussion<br>Role playing<br>Other: Online discussion groups | Self-assessment<br>Objective testing (e.g., multiple-choice question tests and/or test banks)<br>Essay/report<br>Group project (e.g., report, presentation)<br>Role play<br>Review of videotapes or audiotapes |
| | 24 months (300 hours) | Didactic instruction (e.g., lecture/ presentations)<br>Case-based learning<br>Problem-based learning<br>Small-group discussion<br>Role playing<br>Standardized patients/clients<br>Learning activities involving direct service to clients/patients | Self-assessment<br>Peer assessment<br>Personal learning diary<br>Role play<br>Review of videotapes or audiotapes<br>Other: Review of cases |
| | 10 months (20 hours) | Didactic instruction (e.g., lecture/ presentations)<br>Case-based learning<br>Problem-based learning<br>Small-group discussion | Other: No formal assessment of the learners. The learners do give feedback on the individual sessions. There is also an "impact on practice" questionnaire given a number of months after the course is over |

| Institution | Name of course/ workshop/ module | Goal/purpose | Level of learners/students | |
|---|---|---|---|---|
| McMaster University (as above) | Psychiatry residency | Helps psychiatric residents learn to consult and work with primary care practitioners in a "shared care" model. The psychiatry residents work directly in family practitioners' offices for one half day per week over a six-month outpatient psychiatry rotation | Pre-licensure (e.g., undergraduate/ post-graduate students)<br>Medicine | |
| Medicine Hat College Medicine Hat, Alberta Division of Health Studies | Therapeutic Communication | Designed to provide the foundational knowledge, skills, and self-awareness necessary as students begin their studies in human/ health services or as they move into more specialized communication roles | Pre-licensure (e.g., undergraduate/ postgraduate students)<br>Nursing<br>Occupational therapy<br>Social work<br>Other: Deaf/blind support specialist; massage therapy; paramedic; addictions counselling; child and youth care therapist assistant | |
| Memorial University of Newfoundland St. John's, Newfoundland Faculty of Medicine | Psychiatric Emergency and Crisis Intervention (PEACI) | Psychiatric emergency and crisis intervention course used to train family medicine residents in dealing with psychiatric emergencies and crisis intervention. It is a two day course in each of the two years of residency. It involves family physicians, psychologists, psychiatrists and social workers, as well as legal experts as instructors | Pre-licensure (e.g., undergraduate/ post-graduate students) Medicine | |

| | Setting | Length | Learning activities | Assessment activities |
|---|---|---|---|---|
| | Mixed higher-education and primary ambulatory care service settings | 26 weeks (75 hours) | ∾ Didactic instruction (e.g., lecture/ presentations)<br>∾ Case-based learning | ∾ Self-assessment<br>∾ Other: Direct and indirect supervision of patient care |
| | Higher-education institution | 13 weeks (39 hours theory, 39 hours lab) | ∾ Didactic instruction (e.g., lecture/ presentations)<br>∾ Panel discussion<br>∾ Problem-based learning<br>∾ Large-group discussion<br>∾ Small-group discussion<br>∾ Role playing<br>∾ Standardized patients/clients<br>∾ Learning activities involving direct service to clients/patients | ∾ Objective testing (e.g., multiple-choice question tests and/or test banks)<br>∾ Learning portfolio<br>∾ Personal learning diary<br>∾ Essay/report<br>∾ Group project (e.g., report, presentation)<br>∾ Role play<br>∾ Review of videotapes or audiotapes |
| | Higher-education institution | two days in each of the two years (32 hours) | ∾ Didactic instruction (e.g., lecture/ presentations)<br>∾ Panel discussion<br>∾ Case-based learning· Large-group discussion<br>∾ Small-group discussion<br>∾ Role playing<br>∾ Standardized patients/clients | ∾ Self-assessment<br>∾ Role play<br>∾ Standardized patient/client |

| Institution | Name of course/ workshop/ module | Goal/purpose | Level of learners/ students | Setting | |
|---|---|---|---|---|---|
| Mount Royal College<br>Calgary, Alberta<br>School of Nursing | Psychiatric and Mental Health Nursing | To train nurses at a beginning level to work with clients in acute as well as community settings. To work with a multidisciplinary team to meet the needs of clients to attain and maintain stability within the spectrum of their illness. To promote mental wellness at all levels | Both pre- and post-licensure<br>Nursing | Mixed (includes practicum component at primary, community and tertiary levels) | |
| University of British Columbia<br>Vancouver, British Columbia<br>School of Nursing | NURSING 430 (Health of Specific Populations) | Various seminars, lectures and clinical learning experiences in this course (with a mental-health and geriatric focus) and in several other courses required within the baccalaureate curriculum | Pre-licensure (e.g., undergraduate/ postgraduate students)<br>Nursing | Higher-education institution | |

| | Length | Learning activities | Assessment activities |
|---|---|---|---|
| | 8 weeks of theory (48 hours) and practicum (144 hours) | ↝ Didactic instruction (e.g., lecture/ presentations)<br>↝ Case-based learning<br>↝ Problem-based learning<br>↝ Large-group discussion<br>↝ Small-group discussion<br>↝ Role playing<br>↝ Standardized patients/clients<br>↝ Clinical learning experience (e.g., internship, practicum, traineeship<br>↝ Learning activities involving direct service to clients/patients<br>↝ Other: Group presentations focused on issues in mental health | ↝ Self-assessment<br>↝ Objective testing (e.g., multiple-choice question tests and/or test banks)<br>↝ Attitudinal surveys/ questionnaires· Group project (e.g., report, presentation)<br>↝ Role play<br>↝ Standardized patient/client<br>↝ Objective Structured Clinical Examination (OSCE)<br>↝ Review of videotapes or audiotapes<br>↝ Other: Interactions viewed by instructors during clinical rotations |
| | 12 weeks | ↝ Didactic instruction (e.g., lecture/ presentations)<br>↝ Case-based learning<br>↝ Large-group discussion<br>↝ Small-group discussion<br>↝ Clinical learning experience (e.g., internship, practicum, traineeship<br>↝ Learning activities involving direct service to clients/patients | ↝ Self-assessment<br>↝ Objective testing (e.g., multiple-choice question tests and/or test banks)<br>↝ Personal learning diary<br>↝ Essay/report<br>↝ Group project (e.g., report, presentation) |

| Group | Name of course/ workshop/ module | Goal/purpose | Professionals targeted | Setting | |
|---|---|---|---|---|---|
| British Columbia | | | | | |
| Mood Disorders Association of British Columbia Vancouver, British Columbia | Facilitators' Training | Facilitators' training | Consumers, caregivers, volunteers | Various locations in BC; held in hotels or in office | |
| North Island College Health and Human Services Vancouver, British Columbia | Community Mental Health Worker Program | Prepares front-line employees to work in group homes | Health care providers/ practitioners (specifically caregivers, volunteers, nurses, social workers, psychologists) | North Vancouver Island in a college setting | |

| | Frequency/length | Materials used in delivery | Teaching style | Who teaches/ instructs/ leads | Evaluation/ assessment |
|---|---|---|---|---|---|
| | | | | | |
| | More than once a year (two times a year, six hours per workshop) | MDA facilitators' manual and educational material created by BC Partners Mental Health & Addictions | ↝ Didactic instruction (e.g., lectures, presentations)<br>↝ Problem-based learning<br>↝ Large-group discussion<br>↝ Small-group discussion<br>↝ Role playing/ behavioural rehearsal | Teacher with 20 years experience as a caregiver | Peer assessment |
| | More than once a year (two times per year depending on demand, 45 hours total) | Work-books, videos, handouts, Web-based tools | ↝ Large-group discussion<br>↝ Small-group discussion<br>↝ Role playing/ behavioural rehearsal<br>↝ Learning activities involving direct service to clients/ patients | Nurses, social workers, psychologists | ↝ Self-assessment<br>↝ Objective testing (e.g., multiple-choice questions and/ or test banks)<br>↝ Group project<br>↝ Role play |

# appendixG

## PROGRAM DESCRIPTIONS BY REGION (Phase II)

| Group | Name of course/ workshop/ module | Goal/purpose | Professionals targeted | |
|---|---|---|---|---|
| British Columbia (continued) | | | | |
| University of British Columbia<br>Division of Community Geriatrics<br>Vancouver, British Columbia | Care for Elders | Interdisciplinary education to enhance content learning in geriatric care, physical and mental health and to promote id practice through participation in the modular learning | Co-ordinators, health care providers/ practitioners (specifically nurses, psychiatrists, psychologists, dietitians, pharmacists, occupational therapists and anyone else in the community who is working with seniors at a professional level in health) | |
| University College of the Cariboo<br>School of Social Work and Human Service<br>Kamloops, British Columbia | Mental Health Specialty Program | To provide post-basic specialty training in mental health practice. Designed for nurses, social workers, occupational health workers and other health professions who work in mental health | Caregivers, managers, co-ordinators, health care providers/ practitioners (specifically caregivers, nurses, social workers, occupational therapists) | |
| University College of the Cariboo<br>School of Social Work and Human Service<br>Kamloops, British Columbia | SOCW 440 Social Work and Mental Health | To provide an intro to social work practice in the field of mental health. The course provides introductory knowledge of an interprofessional nature, intended primarily for social work students but open to other disciplines and community practitioners | Academics, health care providers/ practitioners (specifically nurses, social workers, other students, e.g., psychology majors) | |

| | Setting | Frequency/ length | Materials used in delivery | Teaching style | Who teaches/ instructs/ leads | Evaluation/ assessment |
|---|---|---|---|---|---|---|
| | | | | | | |
| | Offered wherever it is asked for; held wherever the community wants it | More than once a year (minimum 33 hours total) | Paper-based, case-based modules with evidence given | Case-based learning | Facilitated by a group member, non-expert facilitator | ↝ Self-assessment<br>↝ Attitudinal surveys/ questionnaires |
| | Kamloops, B.C., in a university/ college (also available by distance education) | Once a year | Work-books, handouts, articles | ↝ Case-based learning<br>↝ Written exercises (distance format) | Nurses | ↝ Self-assessment<br>↝ Essay/report |
| | Kamloops, B.C., in a university/ college | Two times a year (42 hours total) | Textbooks, handouts, articles | ↝ Didactic instruction (e.g., lectures, presentations)· Panel discussion<br>↝ Case-based learning<br>↝ Large-group discussionSmall-group discussion<br>↝ Role playing/ behavioural rehearsal | Social workers | ↝ Objective testing (e.g., multiple-choice questions and/ or test banks)<br>↝ Essay/report<br>↝ Group project |

| Group | Name of course/ workshop/ module | Goal/purpose | Professionals targeted | |
|---|---|---|---|---|
| Alberta | | | | |
| Calgary Health Region<br>Calgary, Alberta | Managing Children's Mental Health Issues in Primary Care | Modules:<br>~ Medication Controversies in Treating Adolescent Depression: A review of the emerging issues and the safe use of SSRIs in treating depressed youth<br>~ Disruptive Behaviour Disorders: Awareness of prevalence, severity, prognosis, comorbidities and treatment options; basic understanding of treatment methods; identify resources for services and education<br>~ Adolescent Mood Disorders: Increased understanding in the diagnosis and treatment of mood disorders in adolescents<br>~ Current Practices in Managing ADHD: More confidently recognize and manage ADHD within family practice; develop awareness of treatment options, comorbidities, common misconceptions and referral information; develop some expertise in managing medications used for ADHD treatment<br>~ Autism and Pervasive Developmental Disorders: Understanding diagnostic categories and the spectrum of autistic disorders; epidemiology, comorbidities and developing multidisciplinary management plans | Health care providers/ practitioners (specifically nurses, social workers, family physicians, psychologists) | |
| Medicine Hat College School of Nursing<br>Medicine Hat, Alberta | Children Exposed to Family Violence | To educate health care professionals on the impact of family violence to children, victims and society as a whole | Health care providers/ practitioners (specifically nurses, social workers, psychologists, child and youth care professionals, addiction counsellors, lawyers, justice workers, police officers, family therapists) | |

| | Setting | Frequency/ length | Materials used in delivery | Teaching style | Who teaches/ instructs/ leads | Evaluation/ assessment |
|---|---|---|---|---|---|---|
| | | | | | | |
| | Online in Alberta | More than once a year; each module is posted online for a month, one month per module | Web-based tools | ~ Didactic instruction (e.g., lectures, presentations)<br>~ Small-group discussion | Psychiatrists | ~ Self-assessment<br>~ Attitudinal surveys/ questionnaires |
| | Medicine Hat, Alta., and Lethbridge, Alta., in a university/ college | Once a year (five-day course, 25 hours total) | Work-books, videos, handouts | ~ Didactic instruction (e.g., lectures, presentations)<br>~ Panel discussion<br>~ Case-based learning<br>~ Large-group discussion<br>~ Small-group discussion<br>~ Learning activities involving direct service to clients/patients | Nurses, social workers | Self-assessment |

| Group | Name of course/ workshop/ module | Goal/purpose | Professionals targeted | |
|---|---|---|---|---|
| Alberta (continued) | | | | |
| Medicine Hat College<br>School of Nursing<br>Medicine Hat, Alberta | Children Exposed to Family Violence: Level 2 | To provide professionals with the tools to address family-violence issues within their professional practice | Managers, coordinators, directors/ executives, academics, health care providers/ practitioners (specifically nurses, social workers, family physicians, psychologists, lawyers, judges, victim-assistance advocates, justice officials, police officers, teachers, child and youth care professionals, paramedics) | |
| Manitoba | | | | |
| Health Science Centre of Winnipeg<br>Department of Psychology<br>Winnipeg, Manitoba | MPS Institute (topics vary) | Topics vary. One-day workshop on a mental health topic with the goals of providing an understanding of the etiology, research findings and best practices in the treatment of a particular disorder | Health care providers/ practitioners | |
| University of Manitoba<br>School of Medical Rehabilitation<br>Winnipeg, Manitoba | Visiting professor-ships | The learning objective will vary according to the topic being presented. Typically the courses are to increase our knowledge or practice in a particular area such as FASD or client-centred practice, etc. | Academics, health care providers/ practitioners (specifically occupational therapists and the public) | |

| | Setting | Frequency/ length | Materials used in delivery | Teaching style | Who teaches/ instructs/ leads | Evaluation/ assessment |
|---|---|---|---|---|---|---|
| | | | | | | |
| | Medicine Hat, Alta., and Lethbridge, Alta., in a university/ college | Once a year (40 hours total) | Work-books, videos, handouts, articles | ↝ Didactic instruction (e.g., lectures, presentations)· Panel discussion<br>↝ Case-based learning<br>↝ Problem-based learning<br>↝ Large-group discussion<br>↝ Small-group discussion<br>↝ Learning activities involving direct service to clients/patients<br>↝ Role playing/ behavioural rehearsal | Nurses, social workers, psychologists | ↝ Self-assessment<br>↝ Attitudinal surveys/ questionnaires |
| | | | | | | |
| | Winnipeg, Man., in a hotel/ conference setting | Offered two times a year, six hours total | Handouts, articles | ↝ Didactic instruction (e.g., lectures, presentations)· Panel discussion<br>↝ Case-based learning<br>↝ Problem-based learning<br>↝ Large-group discussion<br>↝ Small-group discussion<br>↝ Role playing/ behavioural rehearsal | Psychologists | Self-assessment |
| | Winnipeg, Man., at the university | These are offered one to two times per year, but this varies. The topic is not always related to mental health. Usually six to twelve hours over two days | Videos, handouts, articles | ↝ Didactic instruction (e.g., lectures, presentations)<br>↝ Panel discussion<br>↝ Case-based learning<br>↝ Problem-based learning<br>↝ Small-group discussion<br>↝ Learning activities involving direct service to clients/patients | Consumers, occupational therapists | Objective testing (e.g., multiple-choice questions and/or test banks) |

| Group | Name of course/ workshop/ module | Goal/purpose | Professionals targeted | |
|---|---|---|---|---|
| Ontario | | | | |
| Canadian Association of Occupational Therapists<br>Ottawa, Ontario | N/A | Our organization offers two to three workshops each year on a variety of topics, including mental health. Decisions are made each year for the next and are always changing, depending on needs expressed by occupational therapists. They are not part of a routine or ongoing series of workshops offered on a schedule. Each workshop is unique and is not usually offered again | N/A | |
| Canadian Practical Nurses Association<br>Scarborough, Ontario | Mental Health | To introduce or enhance nursing knowledge regarding aspects of client care related to mental health nursing. Achieved through core concepts related to the role of the practical nurse in assessing, planning, implementing and evaluating the care of clients with alteration in psychosocial and behavioural functioning. Includes the contribution of relevant mental health theorists, DSM IV classification, major psychiatric illnesses, an overview of treatment modalities, the nurse-client relationship, legal and ethical aspects of mental health nursing, and care for the caregiver | Consumers, caregivers, managers, directors/ executives, health care providers/ practitioners (specifically nurses) | |

| | Setting | Frequency/ length | Materials used in delivery | Teaching style | Who teaches/ instructs/ leads | Evaluation/ assessment |
|---|---|---|---|---|---|---|
| | | | | | | |
| | N/A | N/A | N/A | N/A | N/A | N/A |
| | Throughout Ontario | More than once a year; two-day program with 12 hours total. The course is delivered upon request from nurses or the institution | Textbooks, work-books, handouts, articles | ~ Didactic instruction (e.g., lectures, presentations)<br>~ Case-based learning<br>~ Large-group discussion<br>~ Small-group discussion<br>~ Role playing/ behavioural rehearsal<br>~ Learning activities involving direct service to clients/patients | Nurses | Peer assessment |

| Group | Name of course/ workshop/ module | Goal/purpose | Professionals targeted | |
|---|---|---|---|---|
| Ontario (continued) | | | | |
| Geneva Centre for Autism<br>Toronto, Ontario | Certificate training programs: SLP, OT, autism | Skill acquisition | Caregivers, health care providers/ practitioners (specifically consumers, caregivers, volunteers, social workers, occupational therapists, educators) | |
| McMaster University Family Medicine Program<br>Hamilton, Ontario | Behavioural Science | To teach family medicine residents psychiatric skills, attitudes and knowledge. It replaces a psychiatric rotation at McMaster University. We meet once per week at the family medicine unit for a half day. We use case presentations, audiovisual tapes of patients and didactic presentations to teach about psychiatry and other behavioural science issues | Family medicine residents | |
| McMaster University Family Medicine Program<br>Hamilton, Ontario | Psychiatry for Family Physicians | Develop psychiatric knowledge for family physicians in the community | Family physicians | |

| | Setting | Frequency/ length | Materials used in delivery | Teaching style | Who teaches/ instructs/ leads | Evaluation/ assessment |
|---|---|---|---|---|---|---|
| | Locations vary; offered in hotels, offices, public spaces (as available) | More than once a year, ten times a year, 30 hours in total | Work-books, videos, handouts, articles | ↝ Didactic instruction (e.g., lectures, presentations)<br>↝ Case-based learning<br>↝ Problem-based learning<br>↝ Small-group discussion<br>↝ Learning activities involving direct service to clients/patients | Social workers, psychologists, occupational therapists, speech-language pathologists, educators, behaviour therapists | ↝ Objective testing (e.g., multiple-choice questions and/ or test banks)<br>↝ Essay/report |
| | Hamilton, Ont., in a university/ college | More than once a year; 300 hours over two years, three hours per week | Videos, handouts, articles | ↝ Didactic instruction (e.g., lectures, presentations)<br>↝ Case-based learning<br>↝ Small-group discussion<br>↝ Problem-based learning<br>↝ Role playing/ behavioural rehearsal<br>↝ Learning activities involving direct service to clients/patients | Social workers, family physicians, psychiatrists | ↝ Self-assessment<br>↝ Peer assessment<br>↝ Review of video/ audiotapes |
| | Hamilton, Ont., in a university/ college | Sept–June each year for a total of 30 hours | Handouts, articles | ↝ Didactic instruction (e.g., lectures, presentations)<br>↝ Case-based learning<br>↝ Small-group discussion | Psychiatrists | Peer assessment |

| Group | Name of course/ workshop/ module | Goal/purpose | Professionals targeted | |
|---|---|---|---|---|
| Ontario (continued) | | | | |
| North York General Hospital<br>North York, Ontario | Reality GP | This is a national MAINPRO-accredited continuing health education program for primary care physicians. It is small-group, case-based learning by a psychiatrist facilitator with groups of primary care physician learners in their local communities across English and French Canada. Workshops consist of a didactic presentation and materials followed by interactive case vignettes of common practice challenges in the treatment of depression and chronic anxiety. Formal objectives are: 1. Participants will receive a concise update of the latest information on the management of depression and chronic anxiety disorders that is relevant to the primary care physician. 2. Participants will improve their clinical management skills of depression and chronic anxiety disorder patients through exposure to a number of challenging video case-vignettes. | Health care providers/ practitioners (specifically family physicians) | |
| Northern College Health Services and Emergency Services<br>South Porcupine, Ontario | Conflict Resolution, Critical Incident Stress Management, Suicide Prevention | Learning objectives geared to target groups of health care providers in community | Caregivers, volunteers, academics, health care providers/ practitioners and students | |
| Ontario Society of Occupational Therapists<br>Toronto, Ontario | OSOT does not offer a set course or program of continuing education. Workshops, sessions at conferences and information resources are offered to members and non-members to promote ongoing professional development | Goals of periodic workshops, conferences are to promote ongoing professional development of members (and non-members who attend) | Health care providers/ practitioners (specifically occupational therapists; OSOT workshops are open to non-members who may be from a variety of other professions) | |

| | Setting | Frequency/ length | Materials used in delivery | Teaching style | Who teaches/ instructs/ leads | Evaluation/ assessment |
|---|---|---|---|---|---|---|
| | Across Canada in local communities | More than once a year; ongoing weekly, total of two hours | Work-books, videos | ~ Didactic instruction (e.g., lectures, presentations)<br>~ Case-based learning<br>~ Small-group discussion<br>~ Standardized patients/ clients | Psychiatrists | Attitudinal surveys/ questionnaires |
| | Timmins, Ont., in a university/ college | Once a year; 80 hours total for all three workshops | Videos, handouts, articles | ~ Didactic instruction (e.g., lectures, presentations)<br>~ Small-group discussion<br>~ Role playing/ behavioural rehearsal | Caregivers, social workers, psychologists | Attitudinal surveys/ questionnaires |
| | N/A | N/A | N/A | ~ Didactic instruction (e.g., lectures, presentations)<br>~ Panel discussion<br>~ Large-group discussion<br>~ Small-group discussion (These vary by workshop.) | Occupational therapists and others (depending on the focus of the workshop) | N/A |

| Group | Name of course/ workshop/ module | Goal/purpose | Professionals targeted | Setting | |
|---|---|---|---|---|---|
| Quebec | | | | | |
| Département des sciences infirmières<br>Université du Québec en Outaouais<br>Outaouais, Quebec | Health Experience: People with Mental Health Problems | To develop knowledge and competence in nursing practice that take the family and environment into account in situations where adults, children and adolescents are experiencing mental health problems in an interdisciplinary context. | Nurses | Laval, Que., in a university/ college | |
| Sciences infirmières et de la santé<br>Université du Québec à Chicoutimi<br>Chicoutimi, Quebec | Nursing Practice in Mental Health | To discover the meaning of certain mental health experiences encountered by individuals, families and groups. To develop the attitudes and skills inherent in caring | Caregivers | Chicoutimi, Que. in a university/ college | |

| | Frequency/ length | Materials used in delivery | Teaching style | Who teaches/ instructs/ leads | Evaluation/ assessment |
|---|---|---|---|---|---|
| | | | | | |
| | More than once a year; three hours per week, two classes (one practical, one theory-based) | Textbooks, videos, articles, Web-based tools, video-conferencing, role play | ↝ Didactic instruction (e.g., lectures, presentations)<br>↝ Case-based learning<br>↝ Problem-based learning<br>↝ Large-group discussions<br>↝ Internet-based exercises | Nurses | ↝ Exams in analytical skills<br>↝ Peer-reviewed presentations<br>↝ Learning portfolios<br>↝ Questions on readings<br>↝ Individual work |
| | More than once a year; 15 weeks for a total of 45 hours | Textbooks, work-books, videos, handouts, articles, Web-based tools | ↝ Didactic instruction (e.g., lectures, presentations)<br>↝ Panel discussions<br>↝ Case-based learning<br>↝ Problem-based learning<br>↝ Large-group discussions<br>↝ Small-group discussions<br>↝ Role playing<br>↝ Learning activities involving direct service to clients/patients | Nurses | ↝ Peer assessment<br>↝ Objective testing (e.g., multiple-choice questions and/or test banks)<br>↝ Attitudinal surveys/ question-naires<br>↝ Personal learning diary<br>↝ Essay/report<br>↝ Group project<br>↝ Role play<br>↝ Standardized patient/ client<br>↝ Review of video/ audiotapes |

| Group | Name of course/ workshop/ module | Goal/purpose | Professionals targeted | Setting | |
|---|---|---|---|---|---|
| Quebec (continued) | | | | | |
| Sciences infirmières et de la santé<br>Université du Québec à Chicoutimi<br>Chicoutimi, Quebec | Certificate in Mental Health | To prepare students to intervene with individuals, families and groups to maintain, improve and restore their health. The program allows students to further develop their theoretical knowledge in mental health; to develop new and necessary skills for working with an individual, the family, groups and the community; to structure individual and group action plans with a view to holistic health; to develop a sense of respect for the independence, competence and skills of an individual, of the family network, of relatives and of the community; and to draw on the strengths of this network in the name of the values of co-operative self-help and solidarity | Community members, academics, health care providers/ practitioners | In all settings covered by the UQAC; offered in an off-campus setting, often a hospital | |
| Newfoundland | | | | | |
| Memorial University of Newfoundland<br>Family Medicine Residency Program<br>St. John's, Newfoundland | Core Content: Psychiatric Emergencies and Crisis Intervention | Assist family doctors in dealing with people in an emergency psychiatric crisis | Caregivers, family physicians | St. John's, Nfld., in a university/ college | |

| | Frequency/ length | Materials used in delivery | Teaching style | Who teaches/ instructs/ leads | Evaluation/ assessment |
|---|---|---|---|---|---|
| | More than once a year; 15 weeks for a total of 45 hours | Textbooks, work-books, videos, handouts, articles, Web-based tools, video conferencing | ~ Didactic instruction (e.g., lectures, presentations)<br>~ Panel discussions<br>~ Case-based learning<br>~ Problem-based learning<br>~ Large-group discussions<br>~ Small-group discussions<br>~ Role playing<br>~ Learning activities involving direct service to clients/patients | Caregivers, nurses, social workers, psychologists | ~ Peer assessment<br>~ Objective testing (e.g., multiple-choice questions and/or test banks)<br>~ Attitudinal surveys/ questionnaires<br>~ Learning portfolio<br>~ Personal learning diary<br>~ Essay/report<br>~ Group project<br>~ Role play<br>~ Standardized patient/ client<br>~ Review of video/ audiotapes |
| | Once a year; 16 hours total | Work-books, handouts, practice sessions | ~ Didactic instruction (e.g., lectures, presentations)<br>~ Panel discussion<br>~ Case-based learning<br>~ Problem-based learning<br>~ Small-group discussion<br>~ Role playing/ behavioural rehearsal<br>~ Standardized patients/ clients | Social workers, family physicians, psychiatrists | ~ Self-assessment<br>~ Role play |

# ENDNOTES


1. UK Centre for the Advancement of Interprofessional Education (CAIPE). IPE explained
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Canadian Collaborative Mental Health Initiative
c/o The College of Family Physicians of Canada
2630 Skymark Avenue, Mississauga, Ontario, L4W 5A4
Tel: (905) 629-0900, Fax: (905) 629-0893
E-mail: info@ccmhi.ca

www.ccmhi.ca

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