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Development, Implementation, and Formative Evaluation of Pre-licensure Workshops Using Participatory Action Research to Facilitate Interprofessional, Client-Centred Mental Healthcare

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Abstract

Background: This study presents a formative evaluation of nine pre-licensure workshops to educate on interprofessional, client-centred mental healthcare. The workshops, informed by the conceptual framework of Orchard, Curran, and Kabene had two key objectives: to stimulate networking and to socialize healthcare providers in working together.

Methods and Findings: A participatory action research (PAR) methodology was used for workshop planning and evaluation. Descriptive surveys and feedback forms using closed- and open-ended questions were used to examine whether the intended population was reached, to determine participant satisfaction, and to investigate to what level program objectives had been implemented. Students (625) from different disciplines attended two-hour after-class workshops. The results indicated that students were interested in learning about interprofessionalism and satisfied in the knowledge, attitude, and skills (practice) they received from the workshops. Participants indicated that they had or intended to use some of their learning about interprofessional practice. Key successful approaches, such as the partnership with psychiatric consumers, were incorporated into later workshop series.

Conclusions: The workshops demonstrated that interprofessional workshops can be one training component for pre-licensure students and can increase academic interest in interprofessional education.

Keywords: Interprofessional training; Participatory action research; Evaluation; Mental healthcare

Introduction

Persons with mental health concerns, homelessness, and other related problems often have major challenges in obtaining services for their needs [1,2]. These challenges have become greater as the provision and coordination of care previously occurring in hospitals has moved to community-based services that are often provided independently by various agencies and healthcare professionals who offer health and other services, such as income support, appropriate housing and nutrition, recreation and leisure activities, legal advice, et cetera [3,4]. The broad range of services needed by this population, whether provided within institutions or the community, requires expanded interprofessional (IP) skills and integrated teams [5,6,7,8,9]. Such requirements are often challenged however, as typically training

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and education is provided in unidisciplinary educational environments that provide profession-specific preparation and identity development [3].

Additionally, the unique needs of persons with mental health concerns necessitate client-centred practice [8,10]. Although the term has many definitions, "client-centred practice" is broadly interpreted as an inclusive approach that recognizes the client's lived experience, values, preferences, needs, and family or home environment [11,12,13]. Research has shown that clients in mental health programs value an IP and client-centred approach, both of which enhance their potential for rehabilitation [14,15,16,17,18]. An IP and client-centred approach does not negate the importance of the professionals' expertise, but it does enable clients with mental health concerns to gain from the expertise of several health professionals in addressing their concerns and helping to develop a shared plan of care.

Current healthcare professionals have limited knowledge and understanding of the roles and responsibilities of their colleagues and clients/families within an IP team [19], and they are not prepared for IP teamwork [20,21]. Not all health professions currently receive extensive IP training and education, and even when they do, this training may not be explicitly from a client-centred perspective [11,22,23]. This is because good IP team functioning can occur without a client-centred approach (as in the case of teams that are highly collaborative but exclude the client from decision-making). Also, a client-centred approach does not necessarily lead to an IP, collaborative approach, for various disciplines see "client-centred" as relevant to their individual, one-on-one interaction with clients. For example, "patient-centred medicine" focuses primely on the patient-physician relationship, and the six interactive components that underlie the foundations of patient-centred medicine do not list IP collaborative practice [24]:

- the assessment of disease and illness;
- integrating the assessment with the understanding of the whole person;
- finding common ground between doctor and patient;
- incorporating prevention and promotion;
- building up a long-term relationship between the doctor and patient; and
- being realistic in allocating resources in practice.

Indeed only recently has there been discussion of "changing the culture" to include IP collaboration within patient-centred medicine [11].

IP, collaborative client-centred practice is complex: it embraces not only the relationship between client and healthcare professional but also the foundations of IP team functioning. Thus, our interest is to expand the perception of client-centred practice that focuses on the individual client–healthcare professional relationship to include IP, collaborative practice. Preparing future professionals within IP environments is a key factor to enhancing the application of IP client-centred practice for both improving the care of persons with mental health concerns and addressing the rising costs of mental illness.

Teamwork and IP collaboration have become important themes in recent years in healthcare practice [25,26]. The underlying rationale is that IP collaborative prac-

tice should provide more effective, efficient, satisfying, and client-centred healthcare services [26,27]. However, various studies have articulated barriers to IP practice, including organizational, systemic, and interactional factors [25,26,27,28]. Organizational, administrative, and decision-making protocols are developed to adhere to regulatory bodies that may be antithetical to IP [25,29]. Systemic barriers include power imbalances among healthcare professionals and also with patients/clients [19,25,30,31,32]. The silo approach to training within different healthcare disciplines often leads to role socialization around profession-specific values, identities, and patterns of practice, creating interactional barriers [3,30,32,33,34]. As San Martín-Rodríguez and colleagues [19] suggest, the educational system is one of the "main determinants of interprofessional collaborative practice, because it represents the principal lever for promoting collaborative values among future health care professionals" (p. 137).

In 2006 the authors received a grant from Health Canada's Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) initiative to facilitate IP collaborative mental healthcare in both education and practice settings, focusing on mental health services to vulnerable populations experiencing issues of housing/homelessness. The rationale for this project was threefold: 1) the complexity of mental health needs requires IP skills and integrated teams to provide a range of services; 2) client-centred care is enhanced by collaboration among IP teams; and 3) pre-and post-licensure education provides limited training in IP.

Project development and implementation

This project, named CIPHER-MH (Collaboration in Inter-Professional Health Education and Research—Mental Health), located in London, Ontario, Canada, consisted of a workshop series and practice site placements. The following stakeholders were involved: (a) psychiatric consumers (persons who have used psychiatric services and were members of Can-Voice, a community survivor support group for persons with mental health problems); (b) community agency partners; and (c) students and faculty members from our University of Western Ontario health discipline partners (medicine, nursing, occupational therapy, physical therapy, psychiatry, psychology, social work). The community agency partners included Can-Voice, the Canadian Mental Health Association, City of London Housing Division, Madame Vanier Children's Services, Mission Services of London, My Sister's Place, Regional Mental Health Care London, Salvation Army, Centre of Hope, the Victorian Order of Nurses, Women's Community House, and Western Ontario Therapeutic Community Hostel (see Forchuk, Vingilis, and Orchard [35] for more details).

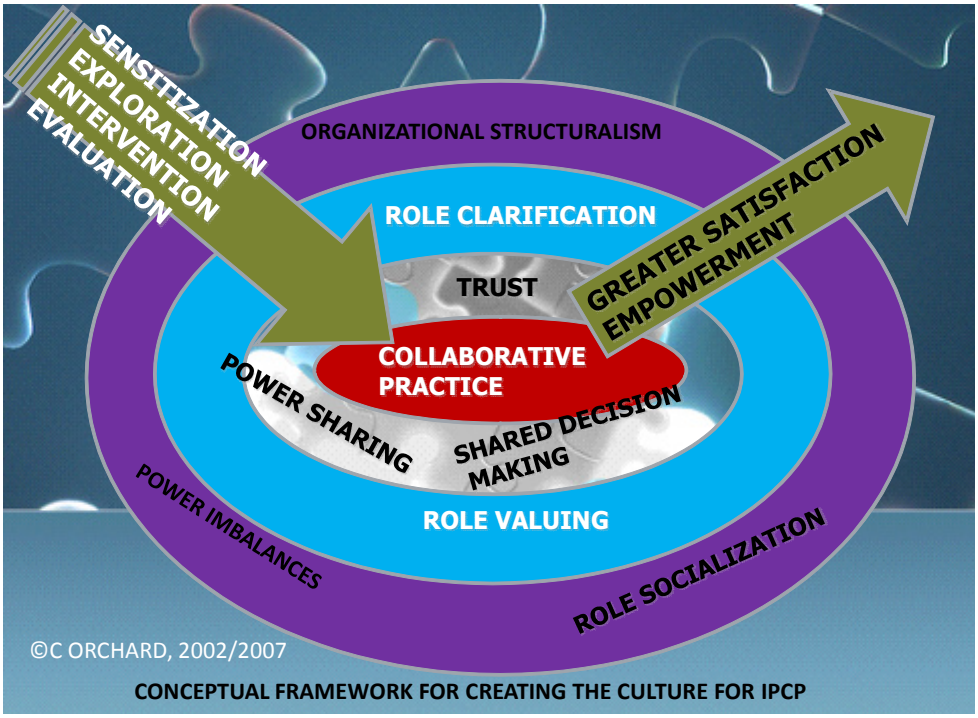
The CIPHER team established four committees (Steering, Curriculum, Practice Site, and Evaluation) to provide oversight to oversee the development, implementation, and evaluation of all project activities. Each committee included project staff, psychiatric consumers, faculty, and students from each involved disciplinary program and staff members of our community agency partners. The Curriculum, Practice Site, and Evaluation committees met monthly to develop and implement

their specific components, and the Steering Committee met bimonthly to oversee and provide general direction for the activities of the various components. Financial stipends were provided to the community partner agencies, students, and participating university departments to offset costs for committee member attendance.

This article presents the results of core component 1, the workshop series. This core component included a series of nine two-hour workshops designed primarily for students in health disciplines, although faculty, psychiatric consumers, and members of other community agencies were also invited to attend. This series of sequentially developed learning modules, based on Orchard et al.'s [25] conceptual framework, were adopted to provide as wide a sensitization process as possible. In this framework, organizational structures—including policies and procedures within institutions that limit collaborative activities—power imbalances between participants and their clients, as well as unidisciplinary socialization are seen to create barriers to IP collaboration. Enablers to transcend these barriers are role clarification and role sharing, leading to role valuing and trust, resulting in shared decision-making and power, thus facilitating IP collaboration. According to Orchard et al.'s conceptual framework, transitioning toward this goal occurs across a four-phased change process, namely (a) sensitization; (b) exploration; (c) implementation; and (d) evaluation. Component 1 of this project focused on sensitization and beginning exploration (see Figure 1). Thus the workshop series was developed to integrate the enablers toward collaborative practice and included the following modules: 1) Awareness; 2) Whose Role Is It Anyway? 3) Gaining Respect; 4) Understanding

Figure 1

Conceptual framework from Orchard, Curran, & Kabene [25] that informed the workshops discussed in this article.



Roles; 5) Collaborative Leadership; 6) The Many Faces of Conflict; 7) Case Coordination; 8) Team Effectiveness; and 9) Putting It All Together (see Appendix 1 for more details on the workshop).

The program's first two overriding general objectives were to 1) stimulate networking and 2) socialize student and other healthcare professionals in working together.

Methods

Participatory action research (PAR) methodology was used [36,37,38] to develop IP learning in both education and practice settings, focusing on mental health services to vulnerable populations experiencing mental health concerns, issues of housing and homelessness, and other related problems.

Speziale and Carpenter [39] suggest that a PAR approach reflects collaborative and consultative processes that use steps in an ongoing cycle of *defining the problem; planning; action; data generation; data analysis and interpretation; and evaluation*. The PAR steps described below were used to guide this project and supported the participation of all stakeholders in shaping the direction of the project and the emergent research processes and evaluation.

Defining the problem: The CIPHER-MH leadership team identified unique issues and needs related to homelessness and mental health and the value of developing IP, client-centred care to support identified needs.

Planning: Orchard et al.'s [25] conceptual framework was used to guide program planning and development. Using an adult learning approach [40,41,42,43], workshop content was developed to be client-centred, interactive, and creative. All committee members, and importantly our psychiatric consumer and student committee members, were significantly involved in the development of the workshop materials. These committee members served in leadership roles during the workshops.

Workshop activities included a play, skits, role play, videos, psychiatric consumer feedback to participants, conversation cafes, small and large group discussions, and the use of realistic case studies focusing on the sessions' workshop themes. These cases were developed and presented by the psychiatric consumers who were integral members of the Curriculum Committee together with other psychiatric consumers who were not committee members but belonged to the same agency (Can-Voice) as our psychiatric consumer committee members. Specifically, each workshop was held during the dinner hours (4:30–6:30 p.m.), during which food was served: it included 10 to 15 minutes of theme content followed by a case presentation, after which small-group IP teams consisting of student participants, psychiatric consumers, other community agency and faculty members (6–10 persons per team) worked through and discussed the case related to the workshop theme of that week. This was followed by 15 to 20 minutes of reflection of student participant experiences, a recap of theme content, debriefing, and presentation of take-home messages. A major focus of all the workshops was to create awareness of client-centredness. The small IP groups of student participants were provided with opportunities to practise their interview skills with the psychiatric consumers, who

play-acted the various case studies at the workshops. The student participants also received feedback on their client-centredness from faculty, psychiatric consumers, and other community agency members. Thus, the workshops provided substantive time for experiential learning, reflection, and discussion [45]. The appendix provides in detail the specific themes and learning objectives for each workshop.

Action: The Curriculum Committee, comprised of IP faculty champions, psychiatric consumers, and students from different disciplines, developed the themes, learning strategies, and implementation plans for the workshops to influence socialization of healthcare students to practise interprofessionally. Electronic notices of workshops were sent to all relevant university departments and community agencies for distribution among faculty, staff, and students, and posters were put up across campus to advertise the workshop series to encourage participation.

Data generation: As part of the action plan, the Curriculum Committee developed specific learning objectives for each workshop. These objectives were provided to the Evaluation Committee, who developed a measurement plan to examine the extent to which the specific learning objectives of each workshop were implemented.

Measures

As there were no available instruments to measure IP collaborative care, or socialization processes within the context of our specific learning environments and objectives [45], three surveys were developed and used. Content validity of the surveys was established using the method of an expert panel [46,47], which included members of the Evaluation Committee (six faculty from medicine, nursing, occupational therapy, psychology, and social work with expertise in questionnaire development, program evaluation, and qualitative and quantitative methods; five student members; one psychiatric consumer; and three CIPHER-MH staff members). Using the principles of good questionnaire design [48, 49,50,51] and informed by other instruments in the field, the Evaluation Committee generated and reviewed a pool of questions to measure general and workshop-specific learning objectives, using the following criteria: focus, brevity, clarity, readability, completeness, and adequacy of response options [49]. The questions underwent numerous revisions. Due to the short period between finalization of workshop content by the Curriculum Committee and the Evaluation Committee's development of the evaluation measures for each workshop, including the time required by the Research Ethics Board (REB) to review each workshop's evaluation questions, receive back and approve the revisions, there were no opportunities to formally pilot test the questions.

As a result of this process, the Interprofessional Interest Survey (IIS), a three-item instrument using a five-point Likert scale (1 = not important at all and 5 = very important) was developed to assess perceived importance of IP education (IPE). The IIS was to be filled out by first-time attendees at the workshops to gather baseline data, although not all first-time attendees completed the instruments (completion was voluntary, as required by the REB). Workshop Feedback Forms (WFF) gauged whether overall and specific learning objectives of each workshop were being implemented. These WFFs, which included Likert-scale, closed-ended ques-

tions (for Workshops 3-8) and open-ended questions (for Workshops 1-9), were developed by the Evaluation Committee after input from the Curriculum Committee about the objectives for each workshop; they were specific to and filled out at the end of each workshop. At the end of the program a Computer-based Feedback Form (CFF) was developed and sent out electronically as a "client satisfaction questionnaire" to participants to obtain their perceptions of the workshop series and to identify whether they both found the series to be useful and used any learning from the workshop content in their practice. The completion of both these instruments was also voluntary.

Data analysis and interpretation: Formative processes were used to evaluate attendance and specific learning objectives, and the data were fed back to the Curriculum and Steering committees, whose members interpreted and used the data to guide their planning and implementation of subsequent workshops. Descriptive statistics were used to analyze the IIS, the attendance and survey questions following each workshop (WFF), and the post-workshop survey (CFF). The open-ended, qualitative questions were analyzed for content on explanations on and expansions to some of the Likert-scale questions and suggestions for improvement. Statistical Package for the Social Sciences (SPSS) was used to analyze the quantitative data, and the open-ended questions were coded, content analyzed, and summarized by two employed research associates who analyzed the phases independently and then met the authors for consensus.

Evaluation: A formative (process) evaluation approach [52] allowed ongoing examination of whether the intended population was reached, levels of participant satisfaction, and levels of program objectives implementation. It did this by capturing perceptions of participants on whether they perceived changes in knowledge, attitude, and skills development (practice) from the content and activities of the workshops. Time limitations of this project (22 months) prevented a full summative evaluation of program outcomes, for no follow-up outcomes data could be collected and no comparison groups were available. The study was approved by the Health Sciences Ethics Review Board at the University of Western Ontario.

Results

Examination of whether the intended population was reached, levels of program objectives implementation of the two key objectives, participant satisfaction, and self-reported use of learning materials were assessed through the closed- and open-ended questions from the IIS, WFF, and CFF.

Objective 1: Stimulate networking

The workshops brought together a diverse community of students, faculty, psychiatric consumers, and other agency members: 734 attended the workshops, although most did not attend all nine workshops. About one-third of participants at each workshop were first-time attendees. This included faculty and students of our partner disciplines and pre-professional programs, community agency staff, psychiatric consumers, and others (including faculty or students of respiratory therapy, speech

language pathology, nutrition, et cetera) (see Table 1). The number of participants, including new participants, is shown in Table 2.

Table 1

Total workshop participants by discipline and status

Type of participant	Frequency	Percent (%)
Occupational therapy	223	30.4
Nursing	153	20.8
Medicine	103	14.0
Psychology	58	7.9
Social work	52	7.1
Physical therapy	49	6.7
Psychiatry	4	0.5
Pre-professional	41	5.6
Other	31	4.2
Community agency	8	1.1
Consumer	12	1.6
Total	734	100.0
Undergraduate student	363	49.5
Graduate student	262	35.7
Faculty	17	2.3
All others	92	12.5
Total*	734	100.0

Note: *Total participants vary, as not all the questions on the forms were completed by the same number of participants. Also, total percent may not equal 100% due to rounding.

Table 2

Workshop participation

Workshop	Participants per workshop*	Total first-time participants
1	87	–
2	72	36
3	71	22
4	83	24
5	112	43
6	121	56
7	133	42
8	107	33
9	158	31

Note: *A number of participants attended multiple sessions.

Undergraduates comprised 56.5% (n = 363) and graduate students comprised 40.8% (n = 262) of attendees. At the University of Western Ontario, occupational therapy, physical therapy, speech language pathology, and clinical psychology are graduate programs, although some undergraduate psychology students also attended.

Feedback from the open-ended question at the end of the Workshop 1 (Awareness) on what participants liked most indicated that a number of participants liked the opportunity to partake in shared learning and networking with each other:

> It is a great opportunity for health care professionals and students to be provided with this type of workshop. They are very beneficial and a great way to interrelate with other health care providers.
>
> [I] liked meeting people from different disciplines.
>
> [The workshop provided an] opportunity to network with others.

Objective 2: Socialize healthcare providers in working together

This objective included three components: awareness and understanding about IP and client-centred care (knowledge); appreciation of and valuing IP practice and client-centred care (attitudes); and comfort and ability in developing skills to function in IP teams (practices). Table 3 provides responses to the Likert-scale questions of the Workshop Feedback Forms (WFF) for Workshops 3 to 8, including response rates for each workshop.

Awareness and understanding (knowledge). As Table 3 shows, workshop participants self-reported increased knowledge for a number of issues, such as awareness of jargon, the importance of being client-centred, the importance of determining leadership criteria, conflicts within IP situations, approaches to handling conflict, IP collaboration, collective responsibility during team interaction, and barriers to effective IP collaboration.

Content analyses of the open-ended questions on the WFF also provided support for increased knowledge of IP and client-centred issues. In Workshop 2 (Whose Role Is It Anyway?), which focused on skills and knowledge of each discipline and the similarities and uniqueness among disciplines, participants were asked to identify the most educational element of the workshop: 40.8% of the 49 who responded to the question identified that the most educational element of the workshop was gaining a better understanding of different professions and the role they play in client care. When asked what they learned most from the workshop, 18.4% of the 49 respondents further commented on learning about role responsibilities, education, and regulation requirements for disciplines other than their own.

> The most educational part … for me [psychology resident], was gaining a better understanding of an OT's profession and understanding the role they play in the life of a patient.
>
> The services offered by other health care professionals are more diverse and varied than I knew.
>
> [I learned about] the different scopes of practice of each profession and the various educational and licensing procedures.
>
> [I learned about] the unique roles that each discipline play in the care of a client—there are areas of overlap where collaboration can be helpful and areas of expertise where each profession brings its own skills.

Knowledge about the importance of IP client-centredness in communications and practice was gained throughout the workshop series. For example, in

Workshop 4 (Understanding Roles), 71% of 39 respondents who expanded further on the open-ended section of the Likert-scale query on whether the activities demonstrated the importance of being client-centred when communicating with clients reflected positively on client-centredness.

> It demonstrated the importance of validating the patient's feeling instead of just pushing ahead with more questions.
>
> It was clear in our reflections that the client felt much better when questions were asked that were client-centred.
>
> It was useful in showing how easy it is to neglect to ask important questions about the client.
>
> We went in circles with the interview process because we didn't include the client and didn't allow the client to identify goals.

In Workshops 6 (Many Faces of Conflict) and 7 (Case Coordination), the open-ended responses to the WWFs emphasized the significance of these educational sessions in creating enhanced awareness of conflict:

> I was very unaware of all the different types of conflict there are and [that] some professionals aren't client-centred.
>
> [I learned] the different conflict triggers. I never noticed or thought about some of them [before].
>
> [I learned] how often IP conflicts arise, how important collaboration between health professionals is.

Appreciation and valuing (attitudes). IP education was perceived to be important by participants. First-time attendees (330 or 44.9% of all attendees completed Interprofessional Interest Survey [IIS]) reflected positive opinions about IP education: the IIS indicated that 63.3% of first-time attendees who completed the IIS valued IP education as very important and 35.4% as important for later collaborative working relationships (response rate: $n = 325$).

Only 1.3% thought IP education not very important. However, when queried on how established IP education was in their profession or agency, 47.2% reported that it was very established/established, while 37.7% reported that it was neutral, and 15.2% reported that it was not established or not established at all. The vast majority thought their profession or agency should be very involved (70.9%) or involved (26.6%).

Table 3 indicates from the Likert-scale questions of the WFFs that the majority of participants thought that the workshops increased their appreciation and valuing of other professionals, psychiatric consumers, and the processes involved in IP collaboration. The majority felt respected by other disciplines and believed the client to be an important member of an IP team.

Content analyses of the open-ended question asking respondents to elaborate on their response to the Likert-scale question on whether they felt respected in

Table 3

Percentage of respondents reporting changes on Likert-scale questions on the Workshop Feedback Forms (WFFs) for Workshops 3 to 8

Workshop	Percentage of respondents				
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
3. Respect and Collaboration ($n = 52$)					
Attitudes: Felt respected by the other disciplines during the collaborative activities	59.6	36.5	3.8	0	0
4. Professional Understanding ($n = 55$)					
Knowledge: Gained awareness of jargon and its impact on IP communication process	25.9	48.1	20.4	3.7	1.9
Knowledge: Activities demonstrated importance of being client-centred when communicating with clients	29.1	61.8	9.1	0	0
Practices: My listening was more effective than before attending this session	29.1	61.8	9.1	0	0
5. Leadership ($n = 85$)					
Knowledge: Activities demonstrated importance of determining leadership criteria	18.8	63.5	16.5	1.2	0
6. Conflict Resolution ($n = 82$)					
Knowledge: Gained an enhanced awareness of conflicts within IP situations	22.9	48.2	13.3	6.0	4.8
Practices: Gained confidence and ability to speak up when encountering a conflict	28.0	63.4	7.3	2.9	1.2
7. Case Coordination ($n = 106$)					
Knowledge: Gained enhanced awareness of approaches to handling conflict	41.0	41.0	14.3	2.9	1.0
Practices: Developed some skills in care plan coordination	31.4	59.8	5.7	1.9	0
8. Assessing Effectiveness ($n = 86$)					
Knowledge: Gained greater appreciation of importance of IP collaboration	32.9	62.4	4.7	0	0
Knowledge: Have better understanding of collective responsibility during team interaction	37.2	51.2	11.6	0	0
Knowledge: Gained greater understanding of barriers to effective IP collaboration	29.1	55.8	15.1	0	0
Attitudes: Believe consumer is an important member of IP team	83.7	16.3	0	0	0

Workshop 3 (Gaining Respect) suggested that respondents attributed this experience of respect to active listening and recognition of unique disciplinary roles and expertise. Of the 35 participants who provided open-ended responses, 30 reported examples:

> Everyone was given an opportunity to speak; questions were openly asked for clarification and collaboration.
>
> Other disciplines were open to hearing different perspectives.
>
> They [participants from other disciplines] were receptive to our discipline's approaches/priorities and incorporated them within the overall plan.

However, five respondents perceived particular disciplines to not be understood or valued:

> People still don't really understand [the] role of OT, and [its] scope of practice.
>
> Contribution of [clinical] psychology seemed undervalued as other disciplines identified psychological issues as quick and simple to treat/address.

In subsequent workshops, participants re-evaluated their attitudes regarding consumers and their roles in the care process. For example, in Workshop 8 (Team Effectiveness), in response to the open-ended question on whether the client is an important member of the IP team, some participants recognized that they held preconceived attitudes regarding psychiatric consumers and identified strategies to communicate effectively with them. Participants reported specific learning, for example:

> I recognized that I need to spend more time reflecting on my preconceived notions of … the mentally ill consumer population.
>
> At times we do not realize [how] our comments or actions affect or [are] receive[d] by others. With the consumer's feedback we are able to reflect back and be more aware of ourselves.
>
> [I learned about] involving the patient as PARTNER.

Comfort and ability (practices). Participants had opportunities at each workshop to develop comfort and ability with skills relevant to IP collaboration. Skills pertaining to active listening, working in teams, conflict resolution, and case coordination were specifically addressed during the nine workshops. As evidenced in Table 3, the majority of participants strongly agreed or agreed that their practice skills had improved in listening, conflict situations, and care plan coordination. In Workshop 4 (Understanding Roles), 39 participants (71%) elaborated on the open-ended section of the Likert-scale question indicating that they had improved their attentiveness and listening to psychiatric consumers, other students, and profes-

sionals, although 22 expressed opinions about the requirements and challenges of IP practice:

> Paying more attention as to why others [from other disciplines] are asking the questions they are.
>
> Each profession can go about getting the information in very different ways. Various perspectives are introduced in the group setting and I learned to listen more effectively to determine what information they were trying to elicit.
>
> So many of our questions overlap so it is important to listen and apply answers to my own profession.
>
> It's sometimes hard to listen to others' questions and the clients' answers when you have a bunch of questions for them yourself.
>
> It's easy for the client to feel disconnected/lost. We all need to listen and react empathetically to what the client is saying, not just continue firing questions.

In Workshop 5 (Collaborative Leadership), in response to the open-ended question on most significant learning, participants identified three broad categories of significant learning: collaboration, leadership, and focus on the client. Participants perceived that they developed skills for choosing a leader and for working through an IP case. Participants identified general criteria for choosing a team leader, including leadership style, knowledge and experience, organizational skills, communication, personal qualities, client-centredness, and miscellaneous criteria, although some commented that the focus was still on medical doctors as leaders.

> A leader needs to know the strengths of the other profession and think outside the box.
>
> No matter what the discipline, we all wanted the same qualities in a leader.
>
> Discipline is not the #1 aspect of choosing a leader; medical doctors should not always be leaders.
>
> [I experienced] that we still seem to look to the doctor as the leader.

After Workshop 6 (The Many Faces of Conflict), participants reported that the most significant learning from the workshop was:

> Learning about the types of conflict, goal conflict, role conflict.
>
> [Learning about] verbal and non-verbal cues [of conflict].

Post-workshop opinions and self-reported use of learning materials

The results of the CFF completed after the workshop series had ended also provided information on participants' opinions on both the program and self-reported

use of workshop materials. Appendix 2 indicates that of those who responded (n = 83), the majority indicated a positive experience: most felt that the workshop series was helpful or extremely helpful. Over half (50.8%) were extremely satisfied with the quality of the workshops, while 1.5% were somewhat dissatisfied. The small-group discussions were endorsed as most useful, and the most useful topic was conflict resolution. The vast majority of participants had made other students or colleagues aware of the workshops and had discussed them with others. Most had used information from the workshops, the most common of which was being information on roles and responsibilities of other professionals, followed by communication across disciplines and communication with clients.

Respondents indicated that they intended to use learning about IP collaborative practice, and a few indicated changes in their practice setting or work. Most had not encouraged students or colleagues to make changes based on knowledge gained from the workshops, although three-fifths indicated that they intended to make future changes as a result of the workshops.

The CFF also confirmed the baseline findings from the IIS about the importance of IP education; most stated it was important or very important. The vast majority thought their profession or agency should be very involved or involved in IP education.

Discussion

Increased community focus and the need for coordination of complex care related to mental health, housing, and related challenges create an ideal opportunity for students to learn about IP practice. This formative evaluation demonstrated participant satisfaction and that the objectives of the workshop series were implemented. The workshops were generally reported to be a positive experience and perceived to be helpful and of good quality. These findings are congruent with IP literature supporting IP workshops as a well-perceived and effective means to improve IP attitudes and behaviours [53, 54,55,56,57]. The various survey results indicated that the student participants were interested in learning about IP practice and were able to reflect on changes to their knowledge, attitudes, and practices occurring within the workshops, as was hoped for in our learning objectives. Specifically, students commented on learning about different disciplines, the importance of being client-centred, and on leadership, conflict, and case management.

Of all the workshop topics presented, the Many Faces of Conflict workshop was ranked as the most useful topic on the CFF that was completed after the workshop series. Considering the reported literature on health practitioners' frequent suppression of conflict and the need to emphasize this in IP education, this result is gratifying [59,60,61]. The Gaining Respect workshop was ranked to be least useful. Curran and colleagues [27] indicated that "respect of all professions" is a key enabler for post-licensure professionals but not for pre-licensure students. It is possible that the pre-licensure students attending our workshops did not have enough experience with respect-related issues in the workplace to appreciate their significance. Alternatively, these participants may already have been socialized to appreciate the

importance of collegial respect, thus seeing the workshop on this topic as less valuable than other workshops.

Importantly, 625 students from different disciplines attended these two-hour, after-class workshops, although few attended all nine. IP learning opportunities can be difficult to organize due to differing schedules across programs and packed curricula [27]. Nevertheless, students were motivated to attend the evening workshop format even without receiving formal credit. Moreover, the evening workshop format allowed students in different programs to learn together. Although this approach may appeal to those already motivated and interested, more formal integration of workshops into curricula would allow us to reach students who may have practical constraints to attendance or who may not yet recognize the importance of IP practice to their future careers.

Three key decisions may have had a positive effect on general student satisfaction with the workshop series. First, we chose to use a developmental sequence of learning workshops over a period of time, utilizing a simple to complex strategy that is advocated by Tough [61] and Davis et al. [62]. In many other efforts to provide workshops, often a single or dual set of workshops is provided and then repeated for new participants. Second, we chose to structure the series around a conceptual framework to ensure coherence in learning development across each workshop, as a successful strategy that is well documented in the IP education literature [63, 64,65,66]. Third, we chose to mix students and faculty members with psychiatric consumers and other community agency members in the workshop small teams group work. None of the participants reported in the feedback that such a mixing interfered with their learning. Rather, the integration of psychiatric consumers into the workshop groups enhanced these workshops immeasurably, as advocated by several authors [10,16,67, 68]. Indeed, the psychiatric consumers played major roles in the educational process in terms of their involvement in curriculum development for the workshops, delivery of the curriculum, provision of feedback, and overall evaluation of the program. Participants reported that involvement of psychiatric consumers resulted in changes in their preconceived attitudes regarding inclusion of psychiatric consumers in their teamwork, in improved strategies to communicate effectively with them, and in a better understanding of client-centredness. We also provided financial stipends for participation at committee meetings, which was particularly important for consumer groups and other agencies to allow them to provide replacements for staff while they were out of the office at our meetings [16].

On the negative side, the overall learning from these workshops may have been less than optimal because participants could come to the workshops at any entry point in the series. Some frustration was voiced through informal feedback provided by a few participants who had been to previous workshops and wanted to move ahead but felt constrained by the need of new learners to catch up on teamwork skills within the group work.

Additionally, although the workshops were primarily for students, we had hoped to have more faculty and agency members who were not part of the different com-

mittees attend the workshops. Fewer faculty and agency members attended than hoped for, although this result may have been a documentation problem. Although all attendees were required to sign in so that we could have a tally of attendees for each workshop, not all of them filled out feedback forms, and thus the background details of all participants may not have been reflected in the descriptive data of professional categories. Barriers to IP education include problems with scheduling, rigid curriculum, lack of reward for faculty, time isolation, administration, attitudes, accreditation, licensing regulations, turf battles, lack of resources, as well as lack of interest or buy-in [7,27,29,69]. Buy-in and adoption of new approaches may be more of a challenge for established professionals where the adoption by these professionals of a new approach may not be compatible with values, beliefs, and past experiences within their social systems [3,34,70]. More attention may be needed to identify enablers of IP (e.g., champions, and financial support) among faculty or agency members [27,34], as professional membership may create "social and cognitive boundaries that impede" [30, p. 61] IP practice. Indeed, healthcare professionals "tend to resist change, operating instead on the premises of internalized norms and care strategies, developed through professional socialization, training, experience, peer culture and organizational structures" [28, p. 130]. There may be greater value in educating students, for they tend to show a high willingness to engage in IP education and thus may be more open to early adoption [70, 71]. The challenge that continues to persist is the lag between preparation of students for their IP practice and the demonstration of collaborative practice within agencies as a norm. More attention is needed to not only prepare students for IP client-centred practice but also for them to act as change agents, implementing IP client-centred practice where it does not currently exist. However, these workshops on IP learning still stimulated grant applications by authors and generate requests from faculty and agency members for further IP teaching and on-site workshops oriented toward practising professionals.

Study limitations

Important limitations to this study need to be noted. This study represents the critical first phase of evaluation, a formative (process) evaluation to assess program implementation, that is, whether the program was implemented as per objectives. Therefore, although participants indicated that they had or intended to use some of their learning about IP collaborative, client-centred practice, we have no evidence of effectiveness of the IP workshops on IP practice and consumer outcomes, a limitation that characterizes much of the research on the effectiveness of IP education [27,71-77]. The design of the study (post-test only design with no control group) was not that of a summative evaluation by which to evaluate changes in outcomes, and in addition to the uncertainty related to the validity and reliability of our measures, does not allow any firm conclusion as to the effects of the workshops on participants' actual learning.

Moreover, participants in this study were interested in IP and thus self-selected; the results could be positively biased. Additionally, given that most did not attend

all workshops, it would be important to learn why. There were also methodological challenges in ensuring that all participants filled out the various feedback forms. Raffles and prizes were used to entice participants to complete feedback forms but, as is evident with the sample sizes for form completions, many did not fill these out. Thus the representativeness and potential bias of the results are impossible to gauge. Additionally, the PAR-developed instruments were not subjected to rigorous psychometric assessment, and therefore the validity and reliability of the measures are not known.

However, the content of our IP project, namely mental health issues, provided an ideal context for students to learn about IP practice, because mental health issues often require the input of many healthcare professionals to coordinate complex care related to mental health, housing, and other challenges. In addition, psychiatric consumers have often experienced treatment that has not been client-centred, so their experiences and feedback can create an awareness and understanding of issues related to client-centred practice.

This first workshop series also provided important information to inform the development of subsequent workshops. A number of successful activities and approaches—such as the partnership with psychiatric consumers—in the development, delivery, and evaluation of the program were incorporated into a later workshop series through the use of standardized patients as group facilitators, and a momentum was observed for interest in IP. Subsequent research should be conducted to assess effectiveness of these IP education programs on actually changing IP and client-centred practice within the healthcare sector.

References

1. Forchuk, C., Joplin, L., Schofield, R., Csiernik, R., Gorlick, C., & Turner, K. (2007). Housing, income support and mental health: Points of disconnection. *Health Research Policy and Systems, 5,* 14-20.
2. Schrecker, T. (1999). *Colloquium report: Making the invisible visible in research on psychiatric de-institutionalization* (CAREMH Report 1). London, ON: Population and Community Health Unit.
3. Glen, S. (1999). Educating for interprofessional collaboration: Teaching about values. *Nursing Ethics*, *6*(3), 202-213.
4. Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Johnsen, M., Goldman, H., Randolph, F., Blasinsky, M., Fontana, A., Calsyn, R., & Teague, G. (1998). Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness. *American Journal of Public Health, 88*(11), 1610-1615.
5. Carpenter, J., & Dickinson, H. (2008). *Interprofessional Education and Training.* Bristol, UK: Policy Press.
6. Kates, N., Gagné, M-A., & Melville Whyte, J. (2008). Collaborative mental health care in Canada: Looking back and looking ahead. *Canadian Journal of Community Mental Health, 27*(2), 1-4.
7. Pauzé, E., Gagné, M-A., & Paulter, K. (2005). *Collaborative mental health care in primary health care: A review of Canadian initiatives. Volume 1: Analysis of initiatives.* Mississaugu, ON: Canadian Collaborative Mental Health Initiative. URL: http://www.ccmhi.ca/en/products/documents/02-Framework-EN.pdf .
8. Tucker, S., Baldwin, R., Hughes, J., Benbow, S. M., Barker, A., Burns, A., & Challis, D. (2009). Integrating mental health services for older people in England—From rhetoric to reality. *Journal of Interprofessional Care, 23*(4), 341-354.
9. Vingilis, E., Paquette-Warren, J., Kates, N., Crustolo, A-M., Greenslade, J., & Newnam, S. (2007). Descriptive and process evaluation of a shared primary care program. *Internet Journal of Allied Health Sciences and Practice*, *5*(4).

10. Gagné, M-A. (2005). *What is collaborative mental health care? An introduction to the collaborative mental health care framework.* Mississauga, ON: Canadian Collaborative Mental Health Initiative.
11. Herbert, C. P. (2005). Changing the culture: Interprofessional education for collaborative patient-centred practice in Canada. *Journal of Interprofessional Care*, *19*(S1), 1-4.
12. Orchard, C., & Curran, V. (2003). *Centres of Excellence for Interdisciplinary Collaborative Professional Practice.* Ottawa, ON: Prepared for Office of Nursing Policy, Health Canada.
13. Sumsion, T., & Law, M. (2006). A review of evidence on the conceptual elements informing client-centred practice. *Canadian Journal of Occupational Therapy, 73*(3), 153-162.
14. Corring, D. J., & Cook, J. (1999). Client-centred care means that I am a valued human being. *Canadian Journal of Occupational Thera*py, *66,* 35-43.
15. Doey, T., Hines, P., Myslik, B., & Leavey, J. E. (2008). Creating primary care access for mental health care clients in a community mental health setting. *Canadian Journal of Community Mental Health*, *27*(2), 129-138.
16. Melville Whyte, J. (2008). Consumer commentary special issue: Collaborative care. *Canadian Journal of Community Mental Health, 27*(2), 11-14.
17. Rebeiro, K. L. (2000). Client perspectives on occupational therapy practice: Are we truly client-centred? *Canadian Journal of Occupational Therapy, 67*(1), 7-14.
18. Sumison, T. (2004). Pursuing the client's goals really paid off. *British Journal of Occupational Therapy, 67*(1), 2-9.
19. San Martín-Rodríguez, L., Beaulieu, M-D., D'Amour, D., & Ferrada-Videla, M. (2005). The determinants of successful collaboration: A review of theoretical and empirical studies. *Journal of Interprofessional Care, 19*(S1), 132-147.
20. Bainbridge, L., & Matthews, M. L. (1999). *Towards new strategies for Managing change in the health professions: A joint initiative.* Vancouver, BC: Health Management Resource Group.
21. Salvatori, P. S., Berry, S. C., & Eva, K. W. (2007). Implementation and evaluation of an interprofessional education initiative for students in the health professions. *Learning in Health and Social Care, 6*(2), 71-82.
22. Clark, P. G. (1995). Quality of life, values, and teamwork in geriatric care: Do we communicate what we mean? *Gerontologist, 35*(3), 402-411.
23. Gilbert, J. H. V., Camp, R. D. II., Cole, C. D., Bruce, C., Fielding, D. W., & Stanton, S. J. (2000). Preparing students for interprofessional teamwork in health care. *Journal of Interprofessional Care, 14*(3), 223-235.
24. Stewart, M., Brown J. B., Weston, W. W., McWhinney, I. R., McWilliam, C. L., & Freeman, T. R. (2003) *Patient-centered medicine: Transforming the clinical method* (2nd ed.). Oxford, UK: Radcliffe Publishing.
25. Orchard, C. A., Curran, V., & Kabene, S. (2005). Creating a culture for interdisciplinary collaborative professional practice. *Medical Education Online, 10,* 1-13.
26. D'Amour, D., Ferrada-Videla, M., Martín-Rodríguez, L. S., & Beaulieu, M-D. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care, 19*(S1), 116-131.
27. Curran, V., Sharpe, D., Flynn, K., & Button, P. (2010). A longitudinal study of the effect of interprofessional education curriculum on student satisfaction and attitudes toward interprofessional teamwork and education. *Journal of Interprofessional Care, 24*(1), 41-52.
28. McWilliam, C. L., & Ward-Griffin, C. (2006). Implementing organizational change in health and social services. *Journal of Organizational Change, 19*(2), 119-135.
29. Parsell, G., & Bligh, J. (1999). The development of a questionnaire to assess the readiness of health care students for interprofessional learning (RIPLS). *Medical Education, 33,* 95-100.
30. McWilliam, C., Kothari, A., Leipert, B., Ward-Griffin, C., Forbes, D., King, M. L., Kloseck, M., Ferguson, K., & Oudshoorn, A. (2008). Accelerating client-driven care: Pilot study for a social interaction approach to knowledge translation. *Canadian Journal of Nursing Research, 40*(2), 58-74.
31. Halpern, S. A. (1992). Dynamics of professional control: Internal coalitions and crossprofessional boundaries. *American Journal of Sociology, 97*(4), 994-1021.
32. Hammick, M. (1998). Interprofessional education: Concept, theory and application. *Journal of Interprofessional Care, 12*(3), 323-332.
33. Clark, P. G. (1997). Values in health care professional socialization: Implications for geriatric education in interdisciplinary teamwork. *Gerontologist, 37*, 441-451.
34. Ginsburg, L., & Tregunno, D. (2005). New approaches to interprofessional education and collaborative practice: Lessons from the organizational change literature. *Journal of Interprofessional Care, 19*(S1), 177-187.

35. Forchuk, C., Vingilis, E., & Orchard, C. (2008). Creating interprofessional collaborative teams of comprehensive mental health services. Final report. Canadian Interprofessional Health Collaborative Library. Retrieved March 21, 2011: http://www.cihc.ca/library/items-by-author?author=Forchuk%2C+Cheryl .
36. Chisholm, R. F., & Elden, M. (1993). Features of emerging action research. *Human Relations, 46,* 275-298.
37. Christie, C. A., Montrosse, B. E., & Klein, B. M. (2005). Emergent design evaluation: A case study. *Evaluation and Program Planning, 28,* 271-277.
38. O'Brien, R. (2001). *An overview of the methodological approach of action research.* URL: http://www.web.net/~robrient/papers/arfinal.html .
39. Speziale, H. J. S., & Carpenter, D. R. (2003). *Qualitative research in nursing: Advancing the humanistic imperative.* Philadelphia, PA: Lippincott Williams & Wilkens.
40. Mast, M. E., & Van Atta, M. J. (1986). Applying adult learning principles in instructional module design. *Nurse Educator, 11*(1), 35-39.
41. Merriam, S. B. (2001). Andragogy and self-directed learning: Pillars and adult learning theory. *New Directions for Adult and Continuing Education, 89,* 3-13.
42. Mezirow, J. (1981). A critical theory of adult learning and education. *Adult Education Quarterly, 32*(1), 3-24.
43. Robertson, D. L. (1996). Facilitating transformative learning: Attending to the dynamics of the educational helping relationship. *Adult Education Quarterly, 47*(1), 41-53.
44. Clark, P. G. (2009). Reflecting on reflection in interprofessional education: Implications for theory and practice. *Journal of Interprofessional Care, 23*(3), 213-223.
45. King, G., Shaw, L., Orchard, C. A., & Miller, S. (2010). The interprofessional socialization and valuing scale: A tool for evaluating the shift toward collaborative care approaches in health care settings. *Work, 35,* 77-85.
46. Kirshner, B., & Guyatt, G. (1985). A methodological framework for assessing health indicies. *Journal of Chronic Diseases, 38,* 27-36.
47. Weiler, R. M., Sliepcevich, E. M., & Sarvela, P. D. (1993). Development of adolescent health concerns inventory. *Health Education, 20,* 569-583.
48. Aday, L. A., & Cornelius, L. J. (2006). *Designing and conducting health surveys: A comprehensive guide* (3rd ed.). San Francisco, CA: Jossey-Bass Press.
49. Sudman, S., & Bradburn, N. M. (1983) *Asking questions: A practical guide to questionnaire design.* San Francisco, CA: Jossey-Bass Press.
50. Schwarz, N., & Oyserman, D. (2001) Asking questions about behaviour: Cognition, communication and questionnaire construction. *American Journal of Evaluation, 22*(2), 127-160.
51. Steckler, A., McLeroy, K. R., Goodman, R. M., Bird, S. T. & McCormick, L. (1992). Towards integrating qualitative and quantitative methods: An introduction. *Health Education Quarterly, 19,* 1-8.
52. Weiss, C. H. (1998). *Evaluation: Methods for studying programs and policies* (2nd ed.). Upper Saddle River, NJ: Prentice Hall.
53. Cooper, H., & Spencer-Dawe, E. (2006). Involving service users in interprofessional education: Narrowing the gap between theory and practice. *Journal of Interprofessional Care, 20*(6), 603-617.
54. De'Bell, K. (2008). *Interprofessional education for collaborative patient-centered chronic disease care. University of New Brunswick final report.* Health Canada IECPCP project. Fredericton, NB: University of New Brunswick.
55. Kilminster, S., Hale, C., Lascelles, M., Morris, P., Roberts, T., Stark, P., Sowter, J., & Thistlethwaite, J. (2004). Learning for real life: Patient-focused interprofessional workshops offer added value. *Medical Education, 38,* 717-726.
56. Sharpe, D., & Curran, V. (2008). *Collaborating for education and practice: An interprofessional education strategy for Newfoundland and Labrador. Memorial University of Newfoundland. Final project report*. Health Canada IECPCP project. St. John's, NL: Memorial University of Newfoundland.
57. Burke, D., Herrman, H., Evans, M., Cockram, A., & Trauer, T. (2000). Educational aims and objectives for working in multidisciplinary teams. *Australsian Psychiatry, 8*(4), 336-339.
58. Drinka, T. J. K. (1994). Interdisciplinary geriatric teams: Approaches to conflict as indicator potential to model teamwork. *Educational Gerontology, 20,* 87-103.
59. Nisbett, G., Hendry, G. D., Rolls, G., & Field, M. J. (2008). Interprofessional learning for pre-qualification health care students: An outcome-based evaluation. *Journal of Interprofessional Care, 22*(1), 57-68.

60. Dougherty, K., & Choi, M. (2008). *Interprofessional Network of BC (In-BC) building capacity and fostering system change. College of Health Disciplines, University of British Columbia. Final report.* Health Canada IECPCP project. Vancouver, BC: University of British Columbia.
61. Tough, A. (1979). *The adult's learning projects: A fresh approach to theory and practice in adult learning.* Toronto, ON: OISE Press.
62. Davis, D., Thomson, M. A., Freemantle, N., Wolf, F. M., Mazmanian, P., Taylor-Vaisey, A. (1999). Impact of formal continuing medical education: Do conferences, workshops, rounds, and other traditional continuing education activities change physician behaviour or health care outcomes? *Journal of the American Medical Association, 282*(9), 867-874.
63. Charles, G., Bainbridge, L., & Gilbert, J. (2010). The University of British Columbia models of interprofessional education. *Journal of Interprofessional Care, 24*(1), 9-18.
64. Cooper, H., Braye, S., & Geyer, R. (2004). Complexity and interprofessional education. *Learning in Health and Social Care, 3*(4), 179-189.
65. O'Halloran, C., Hean, S., Humphris, D., & Macleod-Clark, J. (2006). Developing common learning: The new generation project undergraduate curriculum model. *Journal of Interprofessional Care, 20*(1), 12-28.
66. Reeves, S. (2009). An overview of continuing interprofessional education. *Journal of Continuing Education in the Health Professions, 29*(3), 142-146.
67. Irvine, R., Kerridge, I., McPhee, J., & Freeman, S. (2002). Interprofessionalism and ethics: Consensus or clash of cultures? *Journal of Interprofessional Care, 16*(3), 199-210.
68. Walsh, C. L., Gordon, M. F., Marshall, M., Wilson, F., & Hunt, T. (2005). Interprofessional capability: A developing framework for interprofessional education. *Nurse Education in Practice, 5,* 230-237.
69. Mulvale, G., Danner, U., & Pasic, D. (2008). Advancing community-based collaborative mental health care through interdisciplinary family health teams in Ontario. *Canadian Journal of Community Mental Health, 27*(2), 55-73.
70. Rogers, E. M. (1995). *Diffusion of innovations* (4th ed.). New York, NY: Free Press.
71. Hind, M., Norman, I., Cooper, S., Gill, E., Hilton, R., Judd, P., & Jones, S. C. (2003). Interprofessional perceptions of health care students. *Journal of Interprofessional Care, 17*(1), 21-34.
72. Anderson, E. S., & Lennox, A. (2009). The Leicester model of interprofessional education: Developing, delivering and learning from student voices for 10 years. *Journal of Interprofessional Care, 23*(6), 557-573.
73. Barr, H., Hammick, M., Koppel, I., & Reeves, S. (1999). Evaluating interprofessional education: Two systematic reviews for health and social care. *British Educational Research Journal, 25*(4), 533-544.
74. Hammick, M. (2000). Interprofessional education: Evidence from the past to guide the future. *Medical Teacher, 22*(5), 461-467.
75. Reeves, S. (2001). A systematic review of the effects of interprofessional education on staff involved in the care of adults with mental health problems. *Journal of Psychiatric and Mental Health Nursing, 8,* 533-543.
76. Reeves, S., Zwarenstein, M., Goldman, J., Barr, H., Freeth, D., Koppel, I., & Hammick, M. (2010). The effectiveness of interprofessional education: Key findings from a new systematic review. *Journal of Interprofessional Care, 24*(1), 1-12.
77. Trojan, L., Suter, E., Arthus, N., & Taylor, E. (2009). Evaluation framework for a multi-site practice-based interprofessional education intervention. *Journal of Interprofessional Care, 23*(4), 380-389.

Appendix 1

Workshop Summary Table

Overall purpose	Overall objectives	What did we do?	Key take-home messages
Workshop 1: **Awareness: Chaos to Clarity – Surviving the tornado of mental illness**	• Gather data regarding possible ways to collaborate • Build support for IP learning and CIPHER project • Build understanding about IP collaboration and education initiative	• Play: "Surviving the Tornado" to illustrate themes persons with psychiatric illnesses face with getting, losing, and keeping housing • Conversation Café (Collaboration of Ideas & Insights)	• Awareness building and individual thinking on issues related to mental health and housing, IP learning, and collaborative practice • Thought-provoking insight was encouraged and should be sustained when considering these complex issues
Workshop 2: **Whose Role Is It Anyway? Discovering the health sciences**	• Explore skills and knowledge of each discipline • Explore what is unique and what is similar between professions	• Travelled from one health discipline to the next, learning about scopes of practice • Broke out into IP groups to collaborate on issues raised by psychiatric consumers (Can-Voice members) themselves! • Can-Voice participation with consumer perspective case studies	• The impact of unidisciplinary education prevents us from learning how each other practices with their clients • This causes us to develop myths and attitudes toward those who are outside of our practitioner group • We must learn to work with others and value their unique knowledge and skills as well as our own
Workshop 3: **Gaining Respect**	• See and identify shared roles, commonalities • Experience overlap between professions	• Heard a health-related case presented by a psychiatric consumer • Worked alongside others and within own discipline, to find solutions through client-centred care and collaboration	• Preconditions of respect are integrity, trust, complementary moral values, and skills • To gain respect, have to understand people on a personal level and a professional level • Each discipline needs to be respected as well since all have unique knowledge and skills and can contribute • Disciplinary overlap is common. It is important to understand this and work together for a common goal.
Workshop 4: **Understanding Roles**	• Raise awareness of jargon and its impact on effectiveness • Become familiar with key aspects of listening skills • Emphasize importance of being client-centred	• Increased awareness of how communication styles may have impact on relationships with clients and colleagues of different disciplines • Worked through two mental health–related cases in IP groups while putting these essential skills into practice	• Many barriers to effective communication exist, such as unique disciplinary terminology, failure to listen to what is being said, unconscious views toward other disciplines, failure to ensure that all members of a team are allowed to share in group work • It is important to keep the client at the centre and ask these questions: • How effectively do we listen to what our clients tell us about themselves? • How well do we hear what they wish us to provide assistance with? • How are they already managing their health issues?
Workshop 5: **Collaborative Leadership**	• How to use criteria for selection of leader • Developing skills of working through an IP case under leadership • Evaluating the effectiveness	• Discussed issues of leadership • Determined personal criteria for leadership • Chose a leader in different IP teams to work through a complex mental health–related case, developed from real experiences of Can-Voice psychiatric consumers	• Numerous factors are important when choosing an IP team leader. Need to ask ourselves: • What determines the appropriateness of a team leader? • Should the leader always be the same person? • How do we keep the consumer at the centre? • Key elements in leadership (by Posner & Kouzes) • Model the way • Inspire a shared vision • Challenge the process • Enable others to act • Encourage the heart

Appendix 1 (cont.)

Workshop Summary Table

Overall purpose	Overall objectives	What did we do?	Key take-home messages
Workshop 6: **The Many Faces of Conflict**	• Identify different types of conflict • Importance of having team agreements to deal with conflict	• Observed common examples of conflict in an IP healthcare team • Discussed the causes of conflict • Within IP healthcare teams, developed team agreements on conflict • Practised client-centred care	• Many different types of conflicts exist: goal conflicts, role conflicts, conflicts between health professionals and others, conflicts among health professionals • How do teams agree to handle conflicts? • Commitment to freedom of dissent • Willingness to resolve conflict • Commitment to evaluate and manage self • Keep in mind client-centredness • Recognize the client's expertise (their lived experience) • Respect client's values, preferences, and expressed needs • Consider client's context (family, home environment)
Workshop 7: **Case Coordination**	• Handle triggers to conflict • Improve knowledge about approaches to resolving conflict • Increase confidence of team members to speak up during disagreements and enforce team norms	• Within IP healthcare teams, discussed a complex case developed by psychiatric consumers • Accessed an IP team of faculty advisors while coordinating the team's healthcare plan • Practised client-centred care	• Case Coordination: A process and professional service to achieve integrated and cost-effective care to individuals and families • Increased need in the '70s–'80s in response to fragmented care and lack of services, duplication, and high costs of healthcare delivery • The process requires collaboration, coordination, and communication • Core Components: targeting, assessing, care planning, implementing, monitoring, reassessing • An IP team needs to implement shared decision-making with the client, facilitate access to care, enhance integration, and assure appropriateness and accountability

Workshop 8:
 	
Team Effectiveness
	• Client-centredness
	• Collaboration in IP teams
		• In IP teams, determined how to assess effectiveness of care and that of team in an interactive environment with the participation of psychiatric consumers and community partners
		• Input from professionals working for our mental health and homelessness community partners was provided
			• Foci for evaluation of team effectiveness
			• Team process
			• Team member satisfaction
			• Client (consumer) outcome
			• Client relative satisfaction with process and health outcomes
			• When working in a team, it is important to
			  • Learn about the knowledge and skills everyone brings to the team
			  • Respect, trust, and listen
			  • Develop guidelines for dealing with disagreements
			  • Always take time to reflect on the tasks undertaken as a team and analyze for effectiveness

Workshop 9: **Pulling It All Together**	• Gain better understanding of the role of psychiatric consumer in IP team • Identify strategies on how to enter team • Identify strategies for team building • Work through complete case scenario with all health professionals	• Video of case scenario with all health professionals • Small group discussions on strategies for team entry and team building • Feedback by psychiatric consumers on their role in IP teams • Large group discussion and review of key themes of workshop	• Importance of psychiatric consumers on IP teams • Importance of team building • Not all healthcare professionals work with each client • Different professionals will work with clients as needed

Appendix 2

Results of end-of-workshop computer-based feedback form (CFF) (*n* = 83)

Question	Response categories	Percent (%)
1. Overall how would you rate the workshop series?	Extremely helpful	35.4
	Somewhat helpful	55.4
	Neutral	4.6
	Somewhat unhelpful	3.1
	Extremely unhelpful	1.5
2. How satisfied have you been with the quality of the workshops?	Extremely satisfied	50.8
	Somewhat satisfied	43.1
	Neutral	4.6
	Somewhat dissatisfied	1.5
	Extremely dissatisfied	0
3. Which learning formats have been the most useful?	Small group discussion	78.1
	Large group discussion	9.4
	Presentations	9.4
	Individual reflection	3.1
	Video	0
4. Which session/topic has been the most useful?	Conflict resolution	27.9
	Case coordination	19.7
	Professional understanding	13.1
	Consumers' role within the IP team	13.1
	Leadership	11.5
	Awareness	6.6
	Effectiveness	4.9
	Respect	3.3
5. Have you made other students or colleagues aware of the IP workshops?	Yes	92.3
	No	7.7
6. Have you discussed knowledge from the workshops with others in your discipline?	Yes	94.8
	No	5.2
7. Have you discussed knowledge from the workshops with others outside of your discipline?	Yes	69.2
	No	30.8
8. If yes, how?	Face-to-face	96.2
9. Do you plan to discuss the workshops with others in your discipline?	Yes	50.8
	Maybe	35.4
	No	6.2
	Don't know	7.7
10. Do you plan to discuss the knowledge from the workshops with others outside of your organization?	Yes	44.6
	Maybe	38.5
	No	7.7
	Don't know	9.2

Appendix 2 (cont.)

Results of end-of-workshop computer-based feedback form (CFF) (*n* = 83)

Question	Response categories	Percent (%)
11. Have you used the information from the workshops?	Fully	7.9
	Partially	77.8
	Not at all	4.8
	Not sure	9.5
12. If so, what knowledge gained from the workshops have you used?	Roles and responsibilities of other professionals	75.0
	Communication across disciplines	67.9
	Communication with clients	57.1
	Roles and responsibilities of own profession	44.6
	Listening skills with clients	42.9
	Coordination of clients' care among professions	35.7
	Assessing team effectiveness	17.9
	Criteria for identifying a leader in an IPE team	14.3
	Setting agreements to deal with conflicts	25.0
13. If not, please rate your intention to use learning gained from the workshops.	In most situations	12.5
	In many situations	45.8
	In some situations	25.0
	In selected situations	16.7
	Not at all	0
14. Has your use of the knowledge changed a current practice or routine in your practice setting or work?	Yes	29.2
	Maybe	29.2
	No	23.1
	Don't know	18.5
15. Have you encouraged others to make changes based on the knowledge gained?	Yes	39.1
	No	60.9
16. Do you intend to make any changes in future practice as a result of the workshops?	Yes	59.4
	Maybe	25.0
	No	15.6
17. How important do you think IP education is for later collaborative relationships?	Very important	65.3
	Important	34.7
	Neutral	0
	Not important	0
	Not at all important	1.4
18. How established is IP education in your profession/agency?	Very established	7.0
	Established	36.6
	Neutral	39.4
	Not established	15.5
	Not established at all	4.2
19. How involved do you think your profession/agency should be in IP education and collaboration?	Very involved	58.3
	Involved	37.5
	Neutral	4.2
	Not involved	0
	Not involved at all	0