Research and Theory

What do practitioners think? A qualitative study of a shared care mental health and nutrition primary care program

Jann Paquette-Warren, *M.Sc, Population and Community Health Unit, Family Medicine, Schulich School of Medicine and Dentistry, 2nd Floor—Dr. Don Rix Clinical Skills Facility, London, Ontario, Canada N6A 5C1*

Evelyn Vingilis, *PhD, C. Psych, Population and Community Health Unit, Family Medicine, Schulich School of Medicine and Dentistry, 2nd Floor—Dr. Don Rix Clinical Skills Facility, London, Ontario, Canada N6A 5C1*

Jaimi Greenslade, *B. Psych (Hons), Centre for Organizational Psychology, School of Psychology, The University of Queensland, ST LUCIA QLD 4067, Australia*

Sharon Newnam, *B.Psych (Hons), Centre of Philanthropy and Nonprofit Studies, Faculty of Business, Queensland University of Technology, GPO Box 2434, Brisbane QLD 4001, Australia*

Correspondence to: Jann Paquette-Warren M.Sc., Population and Community Health Unit, Family Medicine, Schulich School of Medicine and Dentistry, 2nd Floor—Dr. Don Rix Clinical Skills Facility, London, Ontario, Canada N6A 5C1, Phone: (519) 858-5063, Fax: (519) 661-3878, E-mail: jpaquet3@uwo.ca

Abstract

Objective: To develop an in-depth understanding of a shared care model from primary mental health and nutrition care practitioners with a focus on program goals, strengths, challenges and target population benefits.

Design: Qualitative method of focus groups.

Setting/Participants: The study involved fifty-three practitioners from the Hamilton Health Service Organization Mental Health and Nutrition Program located in Hamilton, Ontario, Canada.

Method: Six focus groups were conducted to obtain the perspective of practitioners belonging to various disciplines or health care teams. A qualitative approach using both an editing and template organization styles was taken followed by a basic content analysis.

Main findings: Themes revealed accessibility, interdisciplinary care, and complex care as the main goals of the program. Major program strengths included flexibility, communication/collaboration, educational opportunities, access to patient information, continuity of care, and maintenance of practitioner and patient satisfaction. Shared care was described as highly dependent on communication style, skill and expertise, availability, and attitudes toward shared care. Time constraint with respect to collaboration was noted as the main challenge.

Conclusion: Despite some challenges and variability among practices, the program was perceived as providing better patient care by the most appropriate practitioner in an accessible and comfortable setting.

Keywords

evaluation, interdisciplinary care, mental health, nutrition

Introduction

Shared health care is a model of integrated health care delivery in which the collaboration among practitioners of different disciplines or with different skills and knowledge allows for the delivery of patient health care by the most appropriate health care practitioner [1,2]. Shared health care is influenced by the quality of collaborative working relationships, the clarity and commonality of objectives, frequent communication among team members, a clear understanding and respect of individual roles and skills within the team, and the general flexibility of practitioners [1–8]. Various labels, such as shared care, multi-disciplinary, interdisciplinary, trans-disciplinary, and integrated care [7,9–11], have been used to describe models of collaborative care, yet there has been relatively little research in the field. Thus, an in-depth understanding of the nature and distribution of responsibility within shared care models is limited [4].

Comprehensive evaluations of an established shared care program are needed to determine their benefits

and challenges and contribute to future program development and patient care [12–15]. The purpose of this study was to obtain the perspective of health care practitioners on the structure, implementation, and functioning of a shared care model: The Hamilton Health Services Organization Mental Health and Nutrition Program. Specifically, the study sought to answer the following questions: (1) what are the goals of the program from the provider perspective?; (2) what are the strengths of the shared care program?; (3) what challenges do the providers face in running the program?; and (4) how efficacious is a shared care model for a variety of populations? Ethics approval was received from the University of Western Ontario Review Board for Health Sciences Research Involving Human Subjects.

Health Service Organizations were introduced in Ontario, Canada, in 1973 as an alternative payment program to promote a multi-disciplinary approach with an emphasis on health promotion and illness prevention [17]. In 1994, the Health Service Organizations introduced the Mental Health Program in Hamilton, Ontario and in 2000, integrated a local Nutrition Program into the organization. Both programs are administered by one central management team. The program's general aims are to increase accessibility to high quality mental health and nutrition health care services in the primary care setting and to enhance the role of the family physician as a provider of mental health and nutrition health care. During the 2002–2003 fiscal year, the program included a total of 146 health care practitioners (79 family physicians, 39 mental health counsellors, 17 psychiatrists, and eight registered dieticians), working part-time or full-time, and dispersed in thirty-eight primary care practices where they have the opportunity to collaborate in providing patients with the best treatment available by the most appropriate provider.

Methods

A qualitative approach was taken using focus group data collection techniques [18–24] to obtain an understanding of the perceptions and experiences of the practitioners working in this shared care program. All practitioners working in the program were invited to participate. To facilitate comparisons among subgroups of practitioners and practice teams, a stratified strategy [19,25] was used where all who accepted the invitation were included in one of six focus groups (1 – eight family physicians; 2 – seven psychiatrists; 3 – thirteen mental health counsellors; 4 – four registered dieticians; 5 – eleven practitioners [Group A: suburban practice group including at least one of each four disciplines listed in groups 1 to 4]; and 6 – ten practitioners [Group B: inner-city practice group including at least one of each four disciplines listed in groups 1 to 4]). This represents 10%, 41%, 33%, and 50% of the family physicians, psychiatrists, mental health counsellors, and registered dieticians involved in the Mental Health and Nutrition Program, respectively. Participants were interviewed in their respective workplace or at the Program's central office. A semi-structured discussion format was applied using seven guiding questions formulated by an expert panel (Table 1). Two investigators served as moderators, one of whom took field notes, and all discussions were tape-recorded and subsequently transcribed verbatim.

In the first step of analysis, an editing organization style was applied using audio tapes and transcripts to generate a list of themes and assign them to various categories: goals, strengths, challenges and target population [18]. The list of themes then served as a coding template for three additional investigators to perform a template style analysis of the transcripts [18]. Any discrepancies were discussed until a

Table 1. Seven focus group guiding questions

Guiding questions		
1	What are the goals of the Program?	
2	Define Shared Care	
	2a	Is your definition of shared care different from how it occurs in your practice (s)?
	2b	What are the factors influencing the different applications of shared care across practices?
3	Do you think shared care has changed the way patients are treated in your practice (s)?	
4	What do you like about working in your practice (s)?	
5	What don't you like about working in your practice (s)?	
6	What types of patients benefit from your practice (s)?	
7	What types of patients do not benefit from your practice (s)?	

consensus was reached. The revised template (list of themes) was used to conduct a content analysis of the data [18]. Also, NVivo, a computer software program, was used to help organize the data and to pull out representative quotations.

Findings

The focus groups revealed numerous themes related to program goals, strengths, challenges and target population (Table 2).

It is important to remember in reading the following sections that all information provided is based on the perspective of the practitioners interviewed and that it may not represent the views of all practitioners working in the Mental Health and Nutrition Program. The following sections include a brief summary of the combined focus groups data, highlighting the main themes using direct quotations and synopses. The complete summary of themes including the results of the content analysis is available from the Population & Community Health Unit (www.uwo.ca/fammed/pchu).

Program goals

The program goals, mentioned by all groups, included accessibility to mental health and nutrition services for a variety of patients, patient empowerment, collaboration/interdisciplinary care, health promotion/disease prevention, as well as early detection and intervention, and more efficient mental health care. The program aims ''to improve the health of our patients,'' ''increase access of some patients who may not otherwise agree to see a psychiatrist,'' provide ''patients [with a chance to have] an input and [contribute] to their own health care plan,'' to have ''people of different disciplines [working] together and [sharing] their expertise,'' ''[to] identify those individuals at risk,'' and to ''treat people and keep them out of the acute crisis emergency room.''

Practitioner education was another goal noted by family physicians, mental health counsellors, psychiatrists, and Group B. The program ''provides education to the family physicians and the social workers and those who work in the program'' to ''improve the knowledge and capability of [practitioners]'' and facilitate ''referrals to tertiary care services or knowledge of services''.

Program strengths

Themes for program strengths were divided into five categories: shared care as a flexible model, key features of shared care, practitioner satisfaction, more efficient patient care, and contributions of the program's central management team. All groups described the definition of shared care as different from how it is applied in practice. ''There's a bit of difference in how you define shared care and the reality of how it does work.'' ''You've got a basic framework... a lot of flexibility and a lot depends on... [practitioners'] strengths,... on the relationship... What works in my office may not work in the other offices.'' The flexibility of the model has led to variability among practices; however, it allows teams to mould shared care according to practice and patient needs. Also, most groups reported the flexibility in treatment protocol and scheduling as essential to treating patients in order of priority and making use of appropriate strategies for patients in the clinic, home, etc. ''We really do have again people coming into the system that I think would not be seen elsewhere because of accessibility [issues].'' Furthermore, the program was described as improving and changing over time in terms of working relationships, organization of the setting, and individual skills.

Key features influencing how shared care works, such as communication, availability of team members, physical space to work simultaneously, individual skills and comfort, working relationships, and family physicians' perspective of shared care were noted by all groups. For example, communication was said to be critical in transferring patient care. ''In an outpatient setting... the same transfer takes place, but doesn't take place with a phone call or a face-to-face contact.'' In the program, ''[we] can make real time adjustments... It's much more flexible and efficient because a lot of things get done without paper work, just by a couple of sentences.'' When practitioners are not available for face-to-face communication, it can occur ''by note or by phone... [but we] find that communication is so much better when you're right onsite.'' Allied practitioners can better ''support the family doctors who deliver mental health services in the community with timely, accessible back-up... as needed.'' ''Different areas of expertise can be relied upon,'' for ''a combination of knowledge,'' which provides ''a safety check or a fail-safe mechanism... everybody is looking out for... the patient.'' In summary, ''the chart is there, you talk in the hallways, the conversation is going on, there is communication going on regularly.'' However, some family physicians ''don't have an interest in dealing with patients who have psychiatric problems... [and others] are very much involved.'' Therefore, ''some offices are definitely using the shared care philosophy and others are sort of still striving towards it.''

Table 2. Program strengths themes of the Hamilton HSO Mental Health and Nutrition Program according to HSO practitioners

THEMES OF PROGRAM STRENGTHS	FPs		MHCs		PSYs		RDs		Group A		Group B		Totals		
P=participants/T=times mentioned/G=how many groups	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#G
Flexible model															
Model definition differs from its application leading to variability among practices (mould to practice needs)	3	6	3	6	7	21	3	5	1	1	2	3	19	42	6
Flexibility in treatment protocol	2	2	4	7					2	2			8	11	3
Program improves and/or changes with time			4	6	2	5	1	1	1	1			8	13	4
Flexibility in scheduling/prioritising according to patient needs			1	1	2	2			1	1	3	3	7	7	4
Key features of shared care															
Direct communication/Indirect communication (charts, notes...)	7	11	8	13	6	16	2	2	7	12	6	10	36	64	6
Availability of allied professionals (for consultation, advice, collaboration) and support/back up of allied providers	7	13	8	10	5	16	3	3	5	10	7	15	35	67	6
Setting (common resources, all providers in same settings)/ Decreased stress for patients	4	12	3	3	4	4	2	2	3	7	6	15	22	43	6
Individual skills and comfort of team members	6	6	3	3	2	2	2	2	2	4	2	2	17	19	6
Relationships among team members	3	4	1	1	5	7	1	1	2	5	3	3	15	21	6
FPs perspective, comfort, and interest in shared care	2	3	5	7	5	9	1	1			1	1	14	21	5
Practitioner satisfaction															
Interdisciplinary team approach/ Collaboration among different providers	6	9	7	14	5	17	3	8	4	8	7	14	32	70	6
Opportunity for formal and informal education with team members (increase skills/knowledge)	3	12	4	4	6	14	4	10	3	6	2	4	22	50	6
Access to detailed patient information, patient history (Integration of patient information) for more holistic approach	5	9	4	7	4	12			3	4	4	4	20	36	5
General expression of satisfaction	3	4	9	13	2	6	1	1	1	1	3	3	19	28	6
Co-worker assistance with external referrals	5	5	1	1	2	2	2	2	2	2	2	6	14	18	6
Independence and flexibility	3	4	1	1	2	2	2	4	2	2	3	3	13	16	6
Opportunity to focus on personal expertise which is valued and respected	3	5	4	7							1	1	8	13	3
Transfer patient care with ease/ Increase comfort in transferring authority of patient care	1	1			5	8	1	1			1	1	8	11	4
Student education/teaching					2	2					1	1	3	3	2
Co-worker assistance re: insurance companies	1	1									1	1	2	2	2
Multiple co-workers/workplaces							2	2					2	2	1

Table 2. *(Continued)*

THEMES OF PROGRAM STRENGTHS	FPs		MHCs		PSYs		RDs		Group A		Group B		Totals		
More efficient patient care															
Accessibility/Comfortable setting/ Opportunity to build trust with patients (part of a familiar system of care- extension of FP)/Patient acceptance and buy-in/Patient empowerment	7	22	9	30	2	2	4	6	6	15	8	23	36	98	6
Better patient care in general	7	13	8	5	4	4	3	7	2	4	3	4	27	37	6
Early detection and intervention/ Preventative care/Health Promotion/ Patient education and education materials	5	11	8	12	4	6	4	7	2	6	4	8	27	50	6
Continuity of Care	2	2	5	8	4	4	3	3	3	5	2	4	19	26	6
Avoidance of hospitalisation or external referrals for decreased burden on traditional system	4	7	1	1	3	5			2	2	1	1	11	16	5
Reduced stigma	1	2	2	2	1	1			1	1	2	3	7	9	5
Clear treatment plan and feedback re: care	2	2							2	2			4	4	2
Central management team															
Support providers and facilitate shared care			3	3	1	1	2	2			1	1	7	7	4
Provide formal education and research opportunities for providers			3	4			2	2					5	6	2

Practitioners appear very satisfied with the interdisciplinary team approach, which provides an opportunity for formal and informal education, as well as access to pertinent patient information. ''Health professionals are seeing the patients and then... chat about the cases''. ''[There are] particular issues that we can make a learning point,... [therefore,] a lot of indirect care can happen efficiently''. When ''there is a bit of a waiting time to get somebody in,... [the psychiatrist] can be very helpful if you need to give him a call and say what can we do in the meantime.'' The program was said to encourage family physicians and mental health counsellors to do more with backup; however, there is ''the flexibility of working at whatever comfort level works for us.'' Furthermore, all groups made reference to an overall general satisfaction with the independence and flexibility provided, and the assistance of co-workers. Family physicians, mental health counsellors, and Group B noted the opportunity to focus on their personal expertise because ''we've got somebody there who can do it [deal with ongoing/ cognitive issues]... It gives us more time to spend on what we are trained to do.'' Less common themes included the opportunity for student education, co-worker assistance in dealing with insurance companies on behalf of patients, and the opportunity to work in multiple settings with multiple co-workers.

Many program features were described as contributing to better patient care and satisfaction. The program makes mental health care part of ''your average day... There's a connection, it doesn't jump agencies... You're just part of the system'' and ''being here onsite,... [we can] go in and meet the person before a referral... to ease that transition'' and ''eliminate all that craziness that happens between the client needing help, to getting it in our service... It takes away a lot of the pressure, a lot of the stress that normally people go through.'' Also, ''we're seeing families with continuity''. By having access to an extensive patient history via the family physician, ''it doesn't feel like you're getting a piece of this person.'' Practitioners believe there is an increase in accessibility for patients because the setting is more comfortable and familiar leading to patient acceptance and buy-in, reduced stigma, patient empowerment, as well as continuity of care. Furthermore, practitioners felt they can offer ''a lot of treatment that doesn't require formal assessment or emergency psychiatric service, admission to hospital, [or] referral to an outpatient services,'' resulting

in a decreased burden on the traditional system. Finally, other themes emerged noting the element of primary care including early detection and intervention, health promotion and preventive care, as well as patient education.

Finally, the central management team was depicted as a facilitator, critical for quality control and improvement, and instrumental in education and research opportunities for practitioners to increase their skills and knowledge and get published.

Program challenges

All groups depicted time constraints as a major limiting factor of shared care. ''The system is a victim of its own success... The rate of case discovery has gone up;'' thus, ''we can't see every patient once a week if you're there a day and a half... [in] more than one practice.'' Furthermore, even though ''the intent is there for good communication,'' ''if you're only there a couple of hours a week then it's really hard to have that kind of sharing going on.'' Also, since not all practitioners have a personal workstation, some must share a common workstation or utilize examination rooms; therefore, they cannot be onsite simultaneously. ''Where the physicians are there at the same time, I feel that the shared care model is working much more effectively... I see a distinction in the referral rate... no-show rate, cancellations.'' ''If you are not here at the same time, it becomes more of a traditional model.'' In addition, registered dieticians pointed out that when working in multiple offices, it can be difficult to have all necessary resources in each office. Most groups attributed time and space challenges to lack of adequate funding.

Mental health counsellors and psychiatrists felt ''there's just not enough structure put in place to define: here's our expectations of what needs to be provided,… [also] how definitive [our] roles [are].'' Since ''[we] all come with different interests and expectations and experiences, I think the program would be immeasurably stronger if there could be greater synchronization, practice by practice.'' In addition, most practitioners noted difficulties in referring to external services because of long waiting lists, stringent intake criteria, patient restraint, and unclear boundaries among services. ''[The] boundary between the outpatient clinics and the Health Services Organization is still somewhat kind of ill-defined'' and ''the psychiatric system sometimes overestimates what we can do within the Health Services Organization.''

Other challenges were discussed such as the standard evaluation forms and the need for a protocol for record keeping to facilitate sharing of information and to avoid legibility problems. No-shows, access for non-Health Services Organization patients, access to specialized staff such as a child psychiatrist, collaboration of registered dieticians with community services to avoid duplication, and a lack of understanding of the effectiveness of nutrition services were also noted. Lastly, ''this particular way of practicing psychiatry in the community only covers a very small percentage of the [population]…If we're saying it works so well, what about all the other people who don't have any access to this.''

Target population of the program

Practitioners were in agreement that at some level, all patients benefit from the program. Specifically, patients with institutional barriers, family problems, general psychiatric ailments, and physical problems such as diabetes, lipidemia, gastrointestinal issues, and patients with low socio-economic status, the elderly, and ethnic groups are those who benefit the most. Patients who need ongoing or frequent counselling, or emergency psychiatric care, such as patients who need vocational or addiction rehabilitation, patients with unstable schizophrenia/bipolar disease, or other unstable severe mental health problems as well as large families, especially when associated with grief or child psychiatric issues, were identified as exceeding the resources of the program, thus, benefiting the least. Meanwhile, if patients are not accepted into an external service promptly, ''[we] keep at it until something happens, either they do get admitted or they get treated, one or the other.'' No matter the diagnosis, practitioners believe patient motivation to be a critical feature of treatment success. However, ''we are not very good at judging who is motivated or not... People surprise you all the time.''

Discussion

Practitioners revealed an overall satisfaction with the program's structure, implementation, and functioning and view it as a critical service in their community. Furthermore, they felt that ''the Health Services Organization does in this city what probably needs to be done elsewhere in Ontario.'' Shared care and collaboration among practitioners was suggested to depend on a number of factors such as the clinical setting, availability of allied professionals, individual skills, working relationships, and personal views of and comfort with shared care. All these factors were said to contribute to a large variability in roles and communication patterns from one practice to the next.

In some cases, practitioners working in multiple offices found the variability and lack of clear roles and expectations to result in misunderstandings and frustration. However, many believe the flexibility allows individual practices to take into account team dynamics, individual skills, logistical issues, and patient needs when establishing the process of collaboration, thus, moulding protocols and procedures to suit the practice and the team. Since the nutrition program was not introduced until 2000, there has been less time for registered dieticians to build relationships and increase the knowledge and skills of practitioners related to nutrition care. Therefore, provision of clearer definitions or development of group consensus regarding protocols and procedures, resource allocation, practitioner responsibilities, and continued nutrition care education may eliminate some ambiguity and occasional practitioner frustration.

However, practitioners were very positive about the educational opportunities for practitioners, patients, and students especially within the program, but also externally. They indicated that the majority of education within the program, occurs informally by discussing cases or simply by having access to detailed patient information in the charts. Some practitioners were more satisfied with face-to-face collaboration than via patient charts and felt it led to better patient outcomes. But, the most common challenge was time to collaborate, communicate, complete patient notes, and collect data. Also, the program's hand-written evaluation forms were said to contribute to legibility issues, which could be eliminated by a computerized chart system. Meanwhile, practitioners recognized the advantages of indirect collaboration through patient charts and forms, noting that that in itself is not always possible in other settings.

Practitioners appeared particularly pleased with accessibility for patients, the opportunity for early detection and intervention and continuity of care, the ease of internal patient referrals, the lack of a strict intake criteria, and the availability of team members for advise, back-up, and support. Furthermore, general consensus was that waiting lists are much shorter in the program, which provides quick and efficient specialized care to patients who would otherwise require an external referral, or would not receive additional care to complement that of the family physicians. Community clinics were described as having very strict intake criteria, long waiting lists, and some practitioners felt it is increasingly difficult for Health Services Organization patients to access community services because the Mental Health and Nutrition Program is perceived to have the resources to attend to all mental health and nutrition issues in-house. Patients can access specialized care and participate in information or therapeutic group sessions, but the Mental Health and Nutrition Program is best suited for patients who do not require ongoing high-intensity, frequent counselling or emergency psychiatric care.

Study limitations

A qualitative approach was appropriate for this study, but led to some limitations. The stratified purposeful sampling technique yielded the voluntary participation of 10%, 41%, 33%, and 50% of the family physicians, psychiatrists, mental health counsellors, and registered dieticians involved in the Mental Health and Nutrition Program, respectively. Thus, the strata may not be representative of all practitioners [21]. Due to the voluntary nature of the study, time and resource constraints, it was not feasible to follow-up with a survey or other method to obtain the perspective of the additional practitioners working in the program nor was it possible to ensure theme saturation. This is certainly something to consider in the future. Furthermore, to ensure participant confidentiality, it was determined by the research team and program stakeholders that demographic information would not be collected other than the occupation title of the participants.

The semi-structured interview format of the focus groups may have enhanced data through participant interaction, but may have reduced response time of individuals who are less verbal and able to share their perspectives and discourage those with different perspectives to speak up [21,22]. The editing and template analysis style both make use of subjective interpretation; however, multiple independent coders were used to improve credibility of findings. Lastly, the study did not include the perspective of patients, which would generate a more complete picture of shared care within this program.

Conclusion

In summary, according to the perspective of its practitioners, it appears that the Mental Health and Nutrition Program is dedicated to advancing interdisciplinary care by having practitioners with various expertise working in a common primary care setting, collaborating to provide appropriate patient care, and helping each other learn about various aspects of health and wellness. The program provides the opportunity for increased access to care, decreased waiting times for early detection and intervention, simultaneous care from multiple practitioners for continuity of care, and patient education to encourage patient

empowerment, health promotion, and disease/injury prevention. Despite a few challenges, the practitioners seem to perceive the program as beneficial and satisfactory to patients, and indicate a personal satisfaction with the shared care model. In conclusion, the practitioners indicated that the program has all the required elements to improving patients' well-being in an efficient and gratifying way.

Future directions

The information provided by this study, in combination with that revealed by the larger process evaluation of the program [16], revealed that a comprehensive outcomes evaluation of the program has the potential to demonstrate whether or not this approach to shared care truly encompasses the key elements for successful shared care leading to not only practitioner satisfaction but also patient satisfaction and improved well-being. If so, this could result in the opportunity to implement some of the strategies found in this program in other delivery models to enhance to health of the population as a whole.

Reviewers

Cheryl Forchuk, RN PhD, Professor, Faculty of Health Sciences, University of Western Ontario, Scientist Lawson Health Research Institute, Canada

Pablo Jeczmien, Dr, MD, MRCPsych. Sussex Partnership, NHS Trust, West Sussex, United Kingdom

One anonymous reviewer

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