ORIGINAL ARTICLE

A Mental Health Care Setting as a Clinical Exposure Site for Interprofessional Education: a Qualitative Study

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ABSTRACT

Background. Interprofessional collaboration is required as a learning outcome for medical school graduates. Clinical exposure to collaborative practice is one of the recommended strategies in the implementation of interprofessional education. Professionals in mental health units customarily engage in collaborative practice and can provide learning opportunities for medical students. Local data on interprofessional collaboration among practitioners in a mental health care setting in the pandemic is limited and merits study.

Objectives. The goal of this study was to determine and then describe factors that influence collaborative practice among health professionals in an inpatient mental health care unit in the pandemic. It aimed to generate recommendations from practitioners on strategies to optimize opportunities for medical students to learn interprofessional collaboration.

Methods. This is a qualitative study which made use of key informant interviews (KIIs) and focused group discussions (FGDs) with members of a multiprofessional mental health team in the mental health unit of a tertiary medical center. Data was analyzed using thematic analysis.

Results. The onset of the COVID-19 pandemic had drastically disrupted health care services and opportunities for interprofessional collaboration. Participants described their roles and identified six factors essential to reenergizing collaborative practice: resources and opportunities for meaningful interaction, quality of relationship and communication among team members, management goals and strategies relevant to the mental health needs and the context of patients and their families, guidelines for collaboration, interprofessional education appropriate to participant levels, and monitoring for quality assurance and improvement. Practical guidelines for promoting the identified factors were outlined. Recommendations to optimize opportunities for interprofessional education were also given.

Conclusion. Six factors were identified and described in the study. These can provide practitioners and students with a frame of reference for participating in and learning from collaborative practice in a mental health care unit as they work with other professionals on a shared concern. Addressing practical issues in real life settings will enhance their capacity to meaningfully collaborate with other professionals in managing patients, institutions, projects, and similar situations.

Keywords: interprofessional education, multiprofessional, mental health, collaborative practice

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INTRODUCTION

Among the major learning outcomes for medical school graduates is to collaborate within interprofessional teams, defined as effectively work in teams in managing patients, institutions, projects, and similar situations.[1] Collaborative practice enables multiple health workers from different professional backgrounds to work together with patients, families, carers, and communities to deliver the highest quality of care.[2] The definitions and models of collaborative practice are as varied as the contexts in which it may be implemented. The common factor is a spirit of cooperation among various stakeholders who get to experience the benefits. Health workers are able to optimally contribute and feel validated. Interactions enable better alignment of management goals. Learners feel included and are able to get meaningfully involved. Patients and family members feel seen, heard, and understood. Human dimensions are given due attention and overall health outcomes are better served.[3]

Interprofessional education prepares students to become "collaborative practice-ready" health professionals. It occurs "when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes." [2]

The core competencies of interprofessional collaboration consist of four (4) themes: roles and responsibilities, ethical practice, communication, and teamwork.[4] Interprofessional collaboration requires an understanding of the contributions made by different health professional groups to patient care. It necessitates the development of advanced level critical thinking skills and a high degree of self-reflection to learn about and appreciate that there are multiple perspectives among the various professions on a range of concerns related to practice. This makes it more likely for one to accept and encourage the contributions of others in one's daily professional practice.[5] It enables appropriate referral to other members of the health care team to ensure the delivery of holistic evidence-based quality care. It promotes constructive appraisal of processes within a supportive environment for the continuous improvement of the standard of practice.[6]

There are a number of frameworks available that can be used to guide the development of programs to address recommended competencies in interprofessional collaboration.[2,4,7] These programs can be designed and implemented through various strategies based on the nature of the courses, the readiness of students, and the competency of the faculty. An important prerequisite is to give students ample opportunity and time to learn about their intended profession first. Once they have gained a more solid understanding of their own profession and acquired more of the core knowledge and skills associated with their discipline, they will have a better sense of themselves as practitioners and an increasing level of confidence in themselves as professionals. Such a foundation will make it less likely for them to be threatened by the views of others, to be even more open to accepting that there are multiple valid perspectives, and to be more introspective about modifying their perspectives on how their profession relates with others.[5] Clinically, students can learn through exposure to units where different professionals work together in assessing, diagnosing, and managing service users.[6]

Mental health units exemplify such units as they customarily employ an interprofessional approach. The complex mental health needs and sociocultural concerns that service users present with are better addressed by professionals from medicine, nursing, psychology, occupational therapy, and social work.[8,9]

Despite the rich knowledge base on collaborative practice, what it means to collaborate in real settings has not been given adequate attention in the literature and it continues to be challenging for healthcare professionals to practice accordingly.[10] In addition, the physical restrictions and demands imposed on healthcare institutions drove healthcare professionals to return to more siloed ways of practice.[11] Furthermore, concerns have been raised about the impact of the pandemic on the achievement of learning outcomes for graduates given how work disruptions have affected exposure to onsite learning experiences.[12] It is therefore worth looking into the actual experience of healthcare professionals on collaborative practice in a healthcare setting to cull out lessons in re-energizing collaborative practice and enhancing interprofessional education.

This paper determined and then described the factors that influence interprofessional collaboration among health professionals in an inpatient mental health care unit and outlined recommendations on strategies to optimize opportunities for interprofessional education.

METHODS

Research Design

The study used a qualitative phenomenological approach which is deemed to be appropriate when trying to understand and explore the meaning that individuals or groups ascribe to a social concern. Given that the researcher works in the study site, a hermeneutic approach was chosen as an acknowledgement of how the researcher's perspective and participation may affect the data collection and analysis. Semi-structured key informant interviews (KIIs) and focused group discussions (FGDs) were used following the constructivist paradigm of using broad and general questions to allow participants to construct the meaning of the situation being explored.[13] The study involved participants working in a 20-bed inpatient mental health unit of a tertiary hospital.

Data Collection

Data collection involved four sources: KIIs, FGDs, document review, and observation of multiprofessional ward meetings. A copy of the questions asked in the interview is shown in Table 1.

Table 1. Interview Questions

1. What do you see as some of the needs from inpatient mental health services of a patient/service user? (patient-centered care)
2. What does it mean to you to be a (insert profession) in the context of inpatient mental health care? (role clarification)
3. In an ideal world, what would a mental health team for inpatient services look like? (collaborative practice)
4. How do you define collaborative practice? (definition of collaborative practice)
5. What advantages are associated with working in a collaborative mental health care team? (values and philosophies)
6. What disadvantages/challenges are associated with working in such a team? (values and philosophies)
7. How do you think communication and care might be affected by working within a collaborative mental health team? (collaborative communication)
8. How would you recommend that interprofessional education be developed and delivered in the current context? (approach and mechanisms for teaching interprofessionalism)
9. How would you recommend that collaborative care be introduced and executed in the current context? (approach and mechanisms for promoting collaborative care)

The focus of the study is the perspective of practitioners. The sampling was purposive to ensure representation among the five different professions. The inclusion criteria involved adequate experience, defined to be a minimum of six months, in the setting under study. The participants were identified thru the directory of the study site and invited to participate by telephone call.

The KIIs and FGDs were held via teleconferencing platform at a schedule convenient for the participants. The sessions were recorded and transcribed.

The KIIs were done using a guide based on literature. The questions were related to the perception of their professional role, their understanding of collaborative practice, and approaches that they can recommend for implementing and teaching interprofessionalism and collaborative practice.

The document review was done on inpatient charts for evidence of processes conducive to interprofessional collaboration as well as on an unpublished manuscript which provided information on past ward meetings. Observation of multiprofessional ward meetings was done to note the manner of interactions among members of the team.

Data Analysis

Analysis of data from the transcriptions for KII was done using thematic analysis. The use of pre-existing categories was avoided.[14,15] A conscious effort was made to stay close to the meaning intended by participants as well as ensure confirmability of observed findings from the manifest content. In vivo coding was used initially and subsequent codes and categories were derived from the data. Resulting common themes (Figure 1) were used as a springboard for discussion in the initial FGD. Relationships between themes were discussed and elaborated on until a consensus was reached among participants on a shared understanding.

Ethical Considerations

The study was approved by the Research Ethics Board of the University of the Philippines Manila with UPMREB code 2021-0651-01. Informed voluntary consent was obtained through oral and written means by the principal investigator and the participants were informed that they could withdraw from the study anytime. The privacy of the participants was protected and any personal information shared was kept confidential.

RESULTS

All invited to participate agreed and gave consent. Both genders were represented among the participants.

The participants had relevant education in a mental health profession and were employed within the system of the setting (the inpatient setting). A total of 11 individuals, namely five psychiatrists, two nurses, one occupational therapist, one psychologist, and two social workers, participated in the study. The work experience of the participants ranged from six months to 27 years (Tables 2 and 3).

The participants in the KIIs consisted of one consultant psychiatrist, one psychologist, one nurse, one social worker, and one occupational therapist. A representative from each of the five professions participated in the FGDs. There was a total of five KIIs and four FGDs conducted. The duration of each interview ranged between 28 minutes to 62 minutes. The FGDs were conducted with various members of the multiprofessional team who may or may not have been a KII participant on account of turnover of some of the original participants. The FGDs were conducted until saturation

Table 2. Characteristics of Participants in Key Informant Interviews (KII)

Profession	Length of work experience
Psychiatrist	17 years
Nurse	27 years
Occupational Therapist	22 years
Psychologist	2½ years
Social Worker	6 months

Table 3. Characteristics of Participants in Focus Group Discussions (FGD)

Participants	Length of work experience			
	FGD 1	FGD 2	FGD 3	FGD 4
Psychiatrist	11 years	5 years	6 months	3 years
Nurse	27 years	16 years	16 years	16 years
Occupational Therapist	22 years	22 years	22 years	22 years
Psychologist	2½ years	2½ years	2½ years	2½ years
Social Worker	6 months	9 months	9 months	9 months

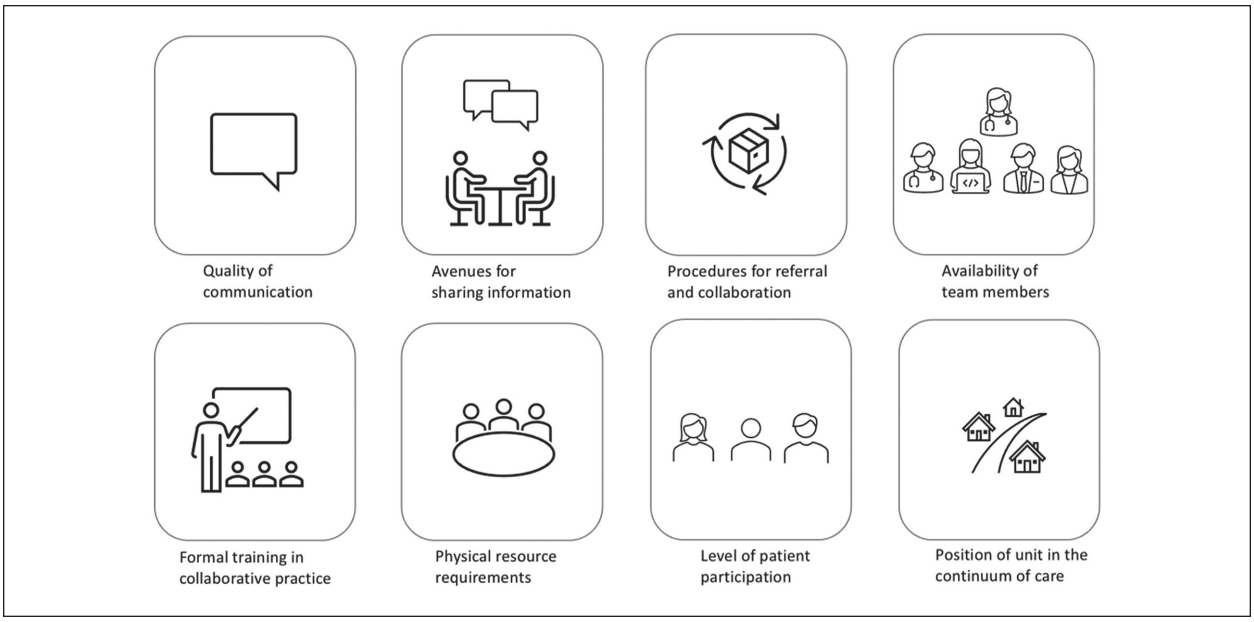

Figure 1. Essential factors of collaborative practice.

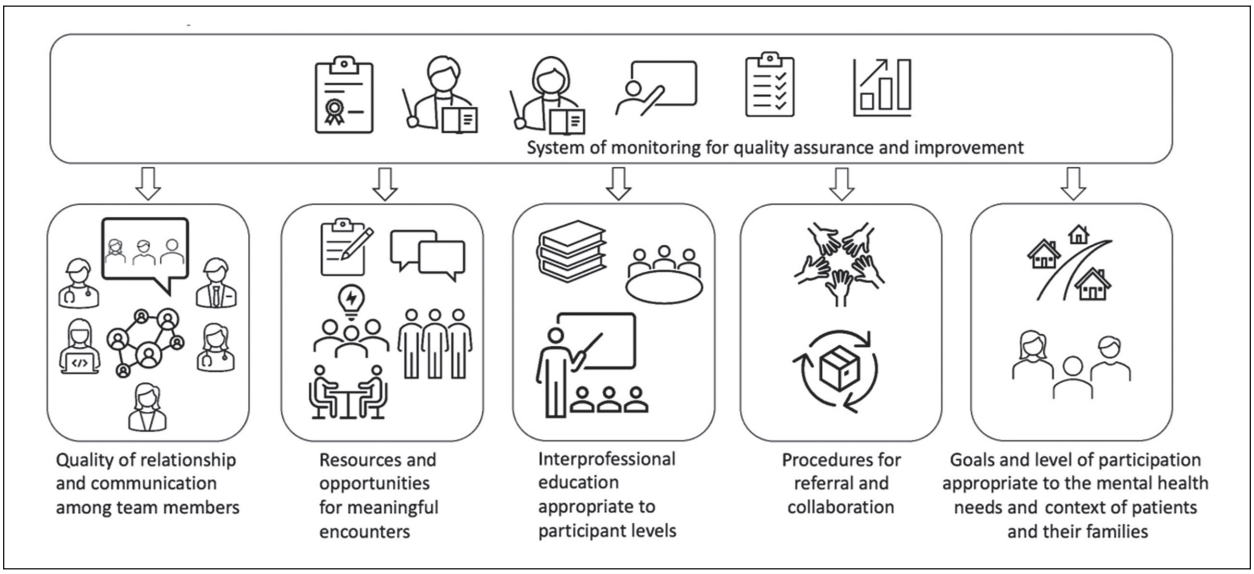

Figure 2. Framework for collaborative practice.

was reached. They lasted about 60 minutes and yielded a framework (Figure 2) applicable to the context. Three ward meetings were observed.

Description of the Roles of Members of the Multiprofessional Team

The physical restrictions and resource requirements at the onset of the COVID-19 pandemic had drastically disrupted services at the study site. When admissions resumed, providers initially worked independently and only uniprofessional face-to-face endorsement rounds were conducted with limited interprofessional interactions. Over time, as virtual platforms were utilized and physical restrictions eased, more interprofessional interactions became possible again.

The psychiatrists assigned to the inpatient unit were first year psychiatry residents who managed patients under the supervision of consultant psychiatrists. In addition to direct patient care duties, they were also assigned on rotation as ward administrators tasked to conduct ward meetings regularly.

The nurses coordinate with the appropriate provider for the diagnostic tests and administers medications as prescribed. They also monitor and assist with activities of daily living and provide counseling as needed. The nurses

were assigned exclusively to the unit but occasionally had to be pulled out for needs in other wards. There were sporadic periods of high turnover.

The occupational therapist assesses the patients' occupational function and plans out and implements structured interactions to restore or maintain related skills while the patient is admitted. Occupational therapists were assigned exclusively to the unit. They are in the inpatient unit regularly and keep to a daily schedule of activities.

The social worker conducts an assessment of the sociocultural situation of the patient and assists with access to needed resources such as diagnostic examinations and medications. The social worker was not assigned exclusively to the unit under study such that visits were done only on some days of the week. They stay in the ward only long enough to accomplish their tasks.

The psychologist was called upon for psychological testing as needed by the psychiatry residents. She also participated in teaching-learning activities of psychiatry residents as requested. The psychologist was exclusively assigned to the unit.

The members of the team were generally clear about their roles in the unit. They were aware of and open to exploring more opportunities for collaboration and better ways of practice.

Essential Factors for Collaborative Practice in the Context of an Inpatient Unit in Mental Health

Collaborative practice was generally understood by participants as pertaining to relationship-building among healthcare providers through the facilitation of meaningful encounters that will enable them to address the needs of inpatients beyond symptom resolution. The inpatient service was seen to be but one along a continuum of services meant to restore the patient to functionality. The informants presented a positive attitude toward collaborative practice and recounted observed and anticipated benefits for the service providers as well as the service users.

Thematic analysis of data from the KIIs yielded eight factors deemed to be essential to collaborative practice as identified by participants (Figure 1). Figures to illustrate the factors were taken from the Icons feature of Word®. The factors identified were quality of communication, avenues for sharing information, procedures for collaboration and referral, availability of team members, structured training in collaborative practice, physical resources, level of patient participation, and the role of the inpatient service as being part of a continuum of care. Direct quotes from professionals were included. They were delineated as M for psychiatrist, N for nurse, O for occupational therapist, P for psychologist, and S for social worker.

Quality of communication. The participants described the importance of sharing information in a form and manner that is readily understood by all. It was recognized that poor communication may lead to gaps or redundancy in management or to conflicting goals of treatment or to delays in referral.

> *P: Sometimes, the goals of treatment differ and may even conflict.*
>
> *N: Good communication promotes socialization and camaraderie among professionals so it is easier to call on them in times of need.*
>
> *O: When we are oriented to the doctor's plans for and expectations from the patient and we are informed about the nursing care provided, we can adjust our management and fill in the gaps.*

Avenues for sharing information. The participants described the importance of avenues for sharing information in a timely manner. Four mediums for collaboration were identified by participants as follows: the ward meeting, the patient chart, bedside rounds, and chance meetings.

> *S: Regular meetings with other staff members involved in care allow for sharing of knowledge and information, and help enhance planning for the patient.*

Ward meeting. Before the pandemic, ward meetings had been held three times a week, with one set of patients discussed per day, and had been traditionally led by the psychiatry resident assigned as ward administrator. An unpublished manuscript[16] provided information on their conduct.

The participants were the psychiatry residents, the nurses, and the occupational therapists. Psychologists were not mentioned while the social worker had never been able to attend any of the ward meetings. The main challenge identified was allotting a common time for the regular conduct of the ward meeting such that they had to be cancelled on some days to give way to other activities. More patients then had to be discussed on the subsequent meeting. There were days when the ward meetings started late and necessitated an extension thus resulting in a disruption in the work schedule. Participating students did not seem sufficiently informed and were ill-prepared to participate meaningfully in the session.

At the time of the study, ward meetings resumed and were observed to be consistently conducted three times a week. They were attended by the five types of health professionals along with students rotating at the time of the meetings. The ward meetings were conducted online twice a week and in-person once a week. Many of the constraints noted[16] were addressed such that representatives of each health profession were more consistently available for the meetings. Participants in the ward meeting were provided with guidelines to enable them to participate meaningfully. An innovation introduced was to rotate the facilitation of the meeting among the different professionals in attendance instead of always the psychiatrist. This allowed all staff members to gain experience in facilitating team discussions and to become more comfortable about initiating interaction with any member of the team and foster more effective communication. The

participants in the study had mixed reactions to attempting a change in the status quo but all agreed that an improvement in communication was worth the effort. It was acknowledged that the role of the psychiatrist in patient assessment and management can be enhanced by encouraging more open two-way communication among team members.

Patient chart. Aside from the medical section for doctor's orders and copies of laboratory results, there were sections for regular entries from the nurses, the occupational therapists, and the psychiatry residents while the social worker logged on only for selected patients with critical concerns. The psychologist had no identified section nor entries in the chart.

Joint bedside rounds. Service providers regularly visited the patients individually while joint rounds with more than one health professional were conducted for selected patients.

Chance meetings. The nurses were the ones who often had spontaneous, unplanned interactions with the other members owing to their consistent presence in the ward. Interactions among the other providers had to be intentionally scheduled and were initiated only as needed.

Guidelines for collaboration. The occupational therapist and the social worker routinely attended to their assessment and management duties while the psychologist generally waited for requests from the resident psychiatrist.

> *P: All services should be informed when there is a new admission even if the patient is not yet ready to be interviewed.*

Availability of team members. For various reasons, the availability of team members was not always assured. The varying composition meant that working relationships had to be constantly redefined based on the participants.

Structured training in collaborative practice. Not all of the participants had received exposure to collaborative practice during their student days and there had been no opportunity to collectively discuss and become more familiar with related concepts and procedures.

> *O: Education in collaboration was not structured. It is an ongoing process of learning as we worked together.*

Physical resource requirements. The pandemic increased the reliance on electronic modes of documentation and communication. Better internet connectivity, the provision of suitable applications, and electronic gadgets have become a necessity. Larger spaces of adequate size and ventilation compliant with safety protocols which are conducive to interactions with patients and their families and among members of the team are also needed.

> *P: It is important to have enough space to conduct assessments and interventions with due consideration for comfort as well as safety from the risk for the transmission of infectious diseases like COVID-19.*
>
> *M: Spaces that offer privacy are needed when talking with the patient so that the patient can discuss sensitive topics and express emotion without being seen by passersby.*

Level of patient participation. Patients and their families varied in their mental health needs, their expectations, their capacity to collaborate. Providers also varied in their perspectives and practices regarding the extent of participation that the patient and the family can have in the planning and implementation of their care.

> *N: The critical part is to make sure that the patients and their families are informed about care plans.*

Position of the unit in the continuum of care. The providers all agree that patient care goes beyond symptom resolution and involves looking into relapse prevention and reintegration to society. The needs of patients extend beyond inpatient care. A system for coordinating and collaborating with providers outside of the unit and even of the institution is needed.

> *N: Our goal is not just to make the patient asymptomatic. We want the person to be functional and productive. We want to provide support to the family too.*

Approach To Challenges with Collaborative Care in the Context of an Inpatient Unit in Mental Health

In the course of the FGDs, some of the factors identified as essential to collaborative practice during the KIIs were noted to be closely linked to each other and were therefore merged. The need for a system to monitor collaborative practice in order *to ensure quality assurance and improvement* was acknowledged.

In putting it all together (Figure 2), collaborative practice in the inpatient unit was described as a systematic, participative, coordinated, and adaptive approach to the provision of responsive care around mental health issues relevant to the context of the inpatients and their families. It can be achieved by enhancing the quality of communication among health care providers through the provision of resources and opportunities for scheduled and unscheduled meaningful interactions. There should be clear guidelines for referral and collaboration, access to appropriate continuing interprofessional education, and mechanisms in place to monitor and continuously improve the process through quality assurance and improvement.

Among the practical guidelines identified relative to each factor in the resulting framework are the following:

1. Provision of resources and opportunities for meaningful interaction among the different members of the team
    a. There should be reliable avenues of communication among service providers. The regular ward meeting, bedside rounds, and the patients' chart are good avenues for information exchange and coordination.

   b. Chance meetings within the premises and for other projects provide additional opportunities for spontaneous collaboration.
   c. Opportunities to interact and collaborate in endeavors within and outside the inpatient unit can significantly contribute to improving relationships and enhancing effective communication.
   d. The provision of various platforms for meeting either virtually or in person can ensure sustainability of interactions among providers even, or especially, during challenging situations like the pandemic.
   e. Better internet connectivity, the provision of suitable applications, and electronic gadgets have become a necessity.
   f. Comfortable spaces for interactions with patients and their families and among members of the team should be compliant with safety protocols.
2. Address the quality of relationships and communication among team members
   a. Rotating the role of facilitator of ward meetings can enhance the quality of communication among service providers.
   b. Ensuring the consistent availability of members of the team is important for fostering better quality of interactions.
   c. Regularly reviewing and processing collaborative experiences among team members can help improve the content, process, and quality of interactions between members.
3. Ensure the alignment of management goals and strategies with the mental health needs and the context of patients and their families
   a. Given that patients and their families vary in their mental health needs, their expectations, and their capacity to collaborate, so too must providers adapt accordingly to ensure responsiveness in their management goals and strategies.
   b. A critical part of patient care is to ensure that the patients and their families are informed about and have adequate understanding of management plans.
   c. Continuity of care even upon discharge from the unit requires close collaboration with providers in the communities of service users.
4. Develop clear structures and processes for collaboration
   a. The delineation of the roles and responsibilities of team members is critical.
   b. There is a need for documentation and periodic review of guidelines and procedures within the team and with health professionals outside the team in the service of patient needs.
   c. Given that participants in collaborative practice change and have varying levels of education, training and experience, there is a need to periodically provide orientation of intended participants to enable meaningful participation. An example given is the proper orientation of incoming staff to ward procedures and practices, as well as protocols that address practical matters such as when, from whom, how and where relevant information can be accessed, whether in the chart, the rounds, or the ward meeting.
5. Provision of teaching-learning activities for interprofessional education which are appropriate to participant levels
   a. Provision of capacity building activities focusing on interprofessional collaboration can help staff and trainees participate more meaningfully in collaborative activities.
   b. Regular review and processing of collaborative experiences among team members can help identify and address emerging needs.
6. Ensure monitoring for quality assurance and improvement
   a. The creation of a unit specifically intended for promoting, developing, and enhancing interprofessional collaboration is necessary.
   b. The provision and regular review of clear policies and procedures will ensure sustainability and continuous improvement.

DISCUSSION

Traditionally, health professionals were trained in isolation from one another and, as a result, received little exposure to the expertise of other professions.[17] Mental health units customarily employ an interprofessional approach such that members are accustomed to working with other professionals toward a shared goal. Mental health professionals who had been trained traditionally generally had to learn "on the job" about how to work with each other.[8]

Since CHED required interprofessional education as a learning outcome in 2016[1], mental health units have been among the exposure sites for collaborative practice where students can witness firsthand how different professionals work together daily toward a shared goal. At the time of the study, interprofessional collaboration had been disrupted by the physical restrictions and the human resource constraints of the pandemic. As a result, participants had been working in isolation or engaging mostly in uniprofessional interactions.

In seeking to describe the experience of actual practitioners, the methodology used provided a platform for the participants in the study site to individually reflect on the subject matter before coming together virtually as a group after a long period with limited opportunity to do so.

The study yielded six factors deemed essential to collaborative practice: *resources and opportunities for meaningful interaction*, *quality of relationship and communication among team members, management goals and strategies relevant to the mental health needs and the context of patients and their families*, *guidelines for collaboration*, *interprofessional education appropriate to participant levels,* and *monitoring for quality assurance and improvement.*

The study addressed the first factor identified and served as a catalyst to promote collaboration. The focus group discussions enabled them to share and agree upon practical guidelines to promote the factors identified. As the members of the unit were just resuming interprofessional interactions, the information shared was a combination of past practices, current efforts, and future aspirations.

Relevance to interprofessional education

The results of the study describe the perspective of health care professionals about collaborative practice. It illustrates how the members of a unit where collaborative practice is meant to thrive strived to reestablish and enhance interprofessional collaboration and dealt with setbacks encountered in the pandemic. The results demonstrate how challenging collaborative practice can be even in a discipline where professionals are accustomed to working together toward a shared goal.

A group of capable people will not spontaneously evolve into a cohesive team unless they are intentionally and consistently supported adequately by appropriate systems and processes. The results of collaboration emerge as team members recognize one another's strengths, develop strategies for leveraging them, and motivate one another to align their efforts in pursuit of a shared goal.

Exposure and immersion of medical students to mental health units as part of interprofessional education can provide a wealth of opportunities for them to appreciate and reinforce competencies relevant to collaborative practice. The exposure to issues encountered at the collaborative practice site which may or may not have been addressed in previous discussions will prepare them to be more responsive to concerns they may encounter later as professionals.

Given the relevance of interprofessional education and the challenges inherent in its implementation, recommendations are in order to optimize opportunities for interprofessional education.

Learning Environment

As the unit provides services and actively faces day-to-day patient care challenges on a regular basis, it is necessary to allot protected time and to assign co-working spaces to ensure opportunities for teaching-learning activities. Structured activities designed to ensure the orientation of the team to collaborative concepts and skills must be embedded in the day-to-day operations of healthcare units. This adjustment will send a message to practitioners and students alike of the value of collaboration and help inculcate a culture of learning.

Facilitator Characteristics

Staff must model good interprofessional practice and communication in their collaboration and facilitation of learning activities. They need to learn and understand each other's professional roles and capabilities and their current curricula. They need to ensure that practice aligns with desired learning outcomes. Those involved in practice and in teaching should exhibit enthusiasm for the endeavor[18] and they must therefore be given sufficient time for team-building[19]. Practicing health professionals will benefit from undertaking targeted professional development to acquire the knowledge and skills currently expected from health professionals in relation to collaborative care.[5,12] This is especially relevant because most of the practicing health professionals at the site were educated traditionally and only learned to work with others on the job. Engaging in continuing professional development will enable them to engage more meaningfully and with greater confidence with other professionals. This will also promote the value of continuous improvement. The most important role of facilitators however is to promote a supportive and inclusive learning environment.[20]

Student Characteristics

As is feasible, students from different professions that rotate at the site can be scheduled to rotate together so that they can undertake collaborative activities together. Interprofessional collaboration requires participants to have a firm knowledge about and appreciation for one's own profession in order for them to have the capacity to appreciate the roles and contributions of other professions. They each bring their uniprofessional-specific knowledge and skills into interprofessional learning to experience the complexity of team-based clinical practice. This means that the exposure they are provided should be appropriate to their level of readiness. Students from different professions must come together in the learning process to achieve their intended learning outcomes in order to gradually progress from uniprofessional to multiprofessional to interprofessional interactions.[5]

Learning Content

The core competencies of interprofessional collaboration consist of four themes: roles and responsibilities, ethical practice, communication, and teamwork[4], and the content of teaching learning activities must address at least one of these competencies. The six factors identified by practitioners can each be studied and addressed using the core competencies of interprofessional education. This will help firm up the understanding and development of the core competencies as well as relate how they can be applied in real life practice. Quality management issues in the unit can also be discussed and critiqued as a team.

Teaching Learning Activities

Structured activities designed to ensure the orientation of the team to collaborative concepts and skills must be embedded in the day-to-day operations of healthcare units. This can take the form of regular orientation and didactic sessions, as well as learning activities such as those recommended by The Centre for Interprofessional Education at the University of Toronto, namely: shadowing and/or

interviewing team members; analyzing interprofessional interactions of team members; and collaborating with team members.[21]

The strategy of utilizing exposure to clinical practice has it premise in Kolb's adult learning theory which involves guided reflection using theory and policy about an interactive experience to promote analysis and consideration of key learnings. Journal clubs and discussion of evidence-based practice are also learning opportunities that can be used to enhance the content of the discussion. The learnings from the guided reflection are then discussed with facilitators to help students and practitioners alike to consider changes that may be introduced in day-to-day practice that may improve patient outcomes.[9,18] Case discussions, interprofessional teaching rounds, and ward meetings can be intentionally structured to enhance their effectiveness in promoting interprofessional education.[22]

Instructional Resources

Initially, tools such as The Interprofessional Collaborative Organizational Map and Preparedness Assessment (IP-COMPASS)[23] or Tomizawa et al.'s Framework for the assessment of interprofessional teamwork in mental health settings[24] can be used by students and practitioners alike to assess, track the progress, and guide the development of collaborative practice in the site. Over time, materials that are more contextually appropriate and culturally acceptable can be developed.

Evaluation of Outcomes

Periodic evaluation on how to improve the learning experience needs to be done and can be conducted easily enough. Assessment to determine whether learning has taken place can be challenging in recognition of differences in the expected outcomes among the different disciplines. It is recommended that formative evaluation would be done in a similar way for the students of different professions as they participate in similar teaching learning activities but methods of summative evaluation will be done differently based on their own expected learning outcomes.

Limitations of the Study

One limitation of this study is the small number of participants available at the study setting. This is due to the limited availability of personnel. To offset this limitation, the participants were purposively selected to be representative of those who are knowledgeable about, significantly involved with, and able to provide rich data about the subject and the context. The study proponent has sufficient training and guidance in data gathering and analysis.

Another limitation is that at the time of the study, the members of the unit were just resuming interprofessional interactions which had been disrupted in the pandemic. With interprofessional collaboration in the unit being at a fairly nascent phase, the focus was on defining boundaries and leveling expectations. Future developments may allow for the determination of factors peculiar to a mental health unit. It may be worthwhile to revisit the setting in a follow-up study to track further challenges encountered and lessons learned from experience.

CONCLUSION

The significance of collaborative practice in health care is well established in theory and practice. The definitions and models of collaborative practice are as varied as the contexts in which it may be implemented. Practitioners in the mental health care unit under study described their roles and identified six factors which influenced collaborative practice during the pandemic: *resources and opportunities for meaningful interaction*, *quality of relationship and communication among team members, management goals and strategies relevant to the mental health needs and the context of patients and their families*, *guidelines for collaboration*, *interprofessional education appropriate to participant levels,* and *monitoring for quality assurance and improvement.* Practical guidelines for promoting the identified factors were outlined. These factors can provide a frame of reference for students as they observe firsthand how different professionals address real life concerns and work on a shared concern toward a shared goal. Exposure to and immersion in collaborative practice in a mental health care unit provides students with opportunities to participate in addressing practical issues in real life settings. Recommendations from practitioners on how to optimize opportunities for interprofessional education within the specific context of the unit can enhance the likelihood of achieving desired learning outcomes. It will help them to be better prepared to actively promote and enhance collaborative practice when they eventually take their place in the health care system with other professionals in managing patients, institutions, projects, and similar situations.

Statement of Authorship

The author certified fulfillment of ICMJE authorship criteria.

Author Disclosure

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