Seeing more than we saw before:

The lived experience of interprofessional practice

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Abstract

This research provides an in-depth exploration of the experience of practitioners and clients utilising an interprofessional practice approach within a community health care setting with clients who have complex chronic care needs. An interprofessional approach has been demonstrated to have enhanced outcomes for clients who have complex chronic conditions. However, interprofessional practice approaches are not well defined in the literature. Therefore, understanding how practitioners and clients co-design healthcare using an interprofessional practice approach requires detailed research within particular healthcare settings. A focus on the management of clients from refugee and asylum seeker background with chronic pain offered a valuable context for this study.

An interpretative phenomenological analysis (IPA) was chosen to support the participants' illumination of lived experience in their interactions with each other. Interviews were conducted with nine practitioners and nine clients. To determine the data's trustworthiness, journaling, member checking, external auditing, and reflexivity were used, all of which align with the IPA approach. The analysis revealed four themes within the practitioners' experience and three themes within the clients' experience.

The first theme to emerge from the practitioner interviews, '*My place within the team'*, illuminated that the interprofessional approach was a natural extension of the values within this community health setting. A strong team focus allowed most members to feel immersed in the interprofessional team. However, some practitioners felt aggrieved by those in the team who did not become as immersed as they did in the

interprofessional activities. They demarcated these practitioners as being on the team's periphery. The second theme, *'Consolidating understanding'*, highlighted how an interprofessional approach initially caused some anxiety due to a fear of the unknown; however, with experience confidence was gained in the teams shared roles and mutual trust developed. The third theme, *'Coping with an interprofessional approach'*, highlighted areas of moral discomfort in the way practitioners reflected on their experience. This discomfort included coping with difficult conversations and using resistance as a protective mechanism. The impact of moral discomfort on the practitioners was reduced by the development of trust and respect which in turn led to the practitioner's willingness to seek each other out for input into client care with an open approach. The fourth theme, *'Finding the balance for the client's benefit'*, highlighted the practitioner's concerns regarding the ethical and moral considerations of an interprofessional approach in this care setting, balanced with the approach's benefits compared to usual care.

Analysis of the clients' experience of an interprofessional approach was limited due to language barriers. However, three themes were revealed: *'The person behind the pain*' that included feelings of uncertainty and holistic needs to be healed, *'Opening up to others*' that included learning to put trust in a team, and *'Ready to move on'* that separated clients into those who were now owing their pain and those who did not move forward.

This study's findings provide useful information about the practical applications of interprofessional practice in a community health care setting that is deficient in the literature. The clinical implications relate to training and processes required to ensure effective interprofessional practice in this setting. The practitioners may have benefitted from additional training, particularly experiential training in applying an

interprofessional approach in practice. Tailored training to their care setting could help overcome the initial anxiety of the unknown and help prepare them for coping with difficult discussions in areas outside their professional practice.

Dedication

To my mother Joan, for inspiring me with her strength and fighting spirit, and to my daughters Ilyna, Calani, Jiorgia and Britany, who have inherited the same strength and make me proud every day.

Declaration

I, Terri Louise Dentry, declare that the PhD thesis entitled *'Seeing more than we saw before: The lived experience of interprofessional practice*' is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

I have conducted my research in alignment with the Australian Code for the Responsible Conduct of Research and Victoria University's Higher Degree by Research Policy and Procedures.

Signature	**Date**
Terri Louise Dentry	10th April, 2021

Acknowledgment

The title of this thesis '*Seeing more than we could see before'* derived from a practitioner interview. The practitioner was acknowledging the efforts of his healthcare team in being able to learn from each other, supporting their own practice with knowledge gained from other professions. In this way, the practitioners were enlightened to the complexity of the needs of their clients, and the interconnections of how other professions along with their own were able to support these needs. This phrase became a symbol of the practitioner's journey within the interprofessional program.

Then, as this research progressed the term '*seeing more'* became increasingly important as it mimicked the inordinate parallel processes that were happening in my understanding of the topics of this thesis. These insightful changes included a deepening understanding of interprofessional practice as a day-to-day process, rather than a shared moment in time, of shared decision-making as a process rather than an event, and of the concept of phenomena to encapsulate the process of an experience, rather than a unique occurrence.

The awakening that these concepts were processes opened the door to an understanding of each of the distinct parts of their makeup. Then learning about each part brought a deeper understanding of the whole, that would not have been possible without the parts – the hermeneutic circle in action, expanding beyond one endeavour to another. These parallel understandings were illuminated with my deepening trust in the process of interpretative phenomenological analysis (IPA) to shine light on the true meaning of the day-to-day lived experience.

My research team were vital in helping me to investigate the meaning of the parts, and to keep digging until all of the parts of the process revealed themselves. They shared their wisdom and provided many hours of firm encouragement to keep me moving forward in this quest.

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List of Abbreviations

AIPPEN	Australian Interprofessional Practice and Education Network
CAIPE	Centre for the Advancement of Interprofessional Education
IPA	Interpretative Phenomenological Analysis
IPP	Interprofessional Practice
NHS	National Health Service
PTSD	Post-Traumatic Stress Disorder
WHO	World Health Organisation

The language used in this thesis

The term '*interprofessional'* emerged from the United Kingdom during the 1960s and, over the past two decades, has become a key focus in the education of health professionals (CAIPE 2002; Cox 2015; WHO 2010). Interprofessional education, interprofessional learning, interprofessional practice, interprofessional collaboration and interprofessional collaborative practice are all frequently used terms within the evolving body of interprofessional literature (Mahler et al. 2014). Throughout this thesis, the term '*interprofessional practice'* has been used to represent intentional interprofessional work by multiple practitioners in a health care setting. The definition of '*interprofessional practice'* provided by the World Health Organisation (WHO) in 2010 most closely resembles this body of research, which is when,

> "*Multiple health workers, from different professional backgrounds, provide comprehensive services by working with clients, their families, carers, and communities to deliver the highest quality of care across settings"* (WHO, 2010).

The nature of the interaction between professionals in providing these complex services in an interprofessional approach has often been referred to as teamwork. However, Reeves, Xyrichis and Zwarenstein (2018) have highlighted that teamwork is only one of the possible ways of working that can be considered interprofessional. In their work to create a new Interprofessional Activity Classification Tool (InterPACT) the terms interprofessional teamwork, interprofessional collaboration, interprofessional coordination, and interprofessional networks have expanded the classification of interprofessional working. For this thesis, the term '*teamwork*' will be

used in a way that aligns with InterPACT, specifically that the team demonstrates the elements of,

> "*shared team identity, clarity, interdependence, integration and shared responsibili'ty*" (Reeves, Xyrichis and Zwarenstein 2018).

The term '*team*' will be used to express,

> "*A small, manageable number of members with an appropriate mix of skills and expertise, who are all committed to a meaningful purpose and have collective responsibility to achieve performance objectives and outcomes. Each team member should have a distinctive and necessary role*" (Reeves 2015).

The terms '*group'* or '*groupwork*' will be used to encompass all other types of working (collaborative, cooperative or networking) involving multiple people undertaking a task. By aligning these terms with the InterPACT model, the term teamwork is a special type of groupwork with a deeper level of interaction and understanding between the members and the intended outcome.

Throughout this thesis, the term '*client/clients'* has been used to represent the person receiving care or services from the health care system.

Prologue

My exposure to the concept of interprofessional practice began at Victoria University in 2012 when I was appointed to a role within the Interprofessional Education and Practice Program (IPEP). My role as Program Manager, together with an Academic Executive and a team of practitioners and project leaders from various professions, helped bring to life a new curriculum program and a new teaching clinic that would be offered to students across ten health disciplines within the university. The primary focus of this program was to teach pre-licensure practitioners how to learn and practice interprofessionally. The program, and my role within this, continued until 2016, with the clinic we collectively designed remaining as a teaching clinic for Victoria University. The interprofessional program inspired many team members to continue working in this field, and I was one of several to embark on a doctoral program.

A doctoral program is a mountain climb. I am not the first or last student to find that analogy so fitting. Nor the first to realise that the grit and determination required to ascend that mountain is all worth it for the clarity when you reach the top. My call to scale this mountain was not my first attempt. In my early 20s, as a young graduate fresh from an honour's degree, I started a similar climb in a different research field that I could not complete due to family commitments. After moving out of the research lab at that time, my career headed into commercial technologies development. I soon became a project manager, a product manager, a program lead, and a project director on several initiatives in and out of universities. Over the years of this doctoral program, my role in technology programs has also progressed,

and I am now in a senior management position with a global systems integration company. In this capacity, I am a people leader and team advocate. I champion my teams to work together in the best ways they can, with client-centered values and an understanding of shared decision-making with each other and with our clients. I respect and appreciate that my manager provides me with the ability to develop autonomy in my team. In a similar way, the members of my team appreciate the many different ways I help them learn from each other and develop strengths in their teamwork.

The research contained in this thesis is a journey of finding an essence that brings people together to collaborate. By examining the lived experience of those who have been part of a team with this essence, I hope to help bring it into the light. In doing so, it will be invaluable to the field of interprofessional practice in healthcare. It will also be invaluable to the field of project management.

Like all professions, project management is finely honed and crafted by each individual who practices before becoming masters. It takes a high degree of competence to be effective in project management in leadership, communication, and stakeholder management. The profession has methods and methodologies crafted by experts and shaped to perfection by experience. The profession carries responsibilities and risks and has accountability for often vast amounts of financial obligation. And, like most professions, being a project manager requires working in complex team settings with team members from various backgrounds and experience. Most universities teach undergraduate and postgraduate degrees in project management, but few project managers understand how to work interprofessionally.

My aim is to use the knowledge gained in this research to reach out to teach others. For this purpose, the Australian Institute of Project Management (AIPM) invited me to present this topic as a session speaker at their national conference in 2019. Then again, in 2020 the AIPM invited me to showcase this topic in a national online lecture series, following the unprecedented global change to the way business teams needed to work together. Understanding how to bring teams together to work collaboratively belongs within all fields of practice, from aviation (where it all began) to healthcare, architecture, law, business, and technology. After this doctoral research, my path will be to continue to help others understand the essence of collaboration in all programs where teams come together from different professions to create something that was not there before.

Chapter One: Introduction

Healthcare is an industry that demands continual change. In the developed world, healthcare services are repeatedly challenged to adapt and accommodate advances in medical science and technological innovations. In the past, acute care services were provided in a hospital setting, and a general physician provided more routine care and chronic care services in their practice or the client's home. However, we now have a network of interconnected acute and chronic care services delivered in hospitals, care homes, physician's rooms, community health centres, and specialist service clinics. Indeed, the World Health Organisation (2018) declared that health services should, *"Deliver quality services to all people, when and where they need them*" (p. 1), encouraging even more diversified care settings into the future.

Along with these changes in healthcare settings, practitioners are also evolving from siloed specialist service models to team-based care designed to focus on complex client needs (Department of Health 2017). New ways of engaging in team-based practice require practitioners to learn to work together, across multiple care settings and with multiple professions. In doing so, hierarchical, leadership and communication hurdles inherent in the old siloed approach need to be overcome.

Interprofessional practice is an approach to team-based care that supports a deep collaboration between practitioners from different professions working in complex care settings (World Health Organisation 2010). Within an interprofessional practice

setting, practitioners from multiple professions work together and with the client to meet the holistic individual needs of the client (D'Amour and Oandasan 2005). The utilisation of an interprofessional practice approach has gained in popularity over the past 20 years (Barr et al. 2008; Paradis and Whitehead 2015), particularly in settings where people living with complex chronic conditions require support from multiple professions to improve health outcomes (e.g. Fleming and Willgerodt 2017; Lutfiyya et al. 2019; Pascucci et al. 2020).

Utilising an interprofessional approach, practitioners work hard to develop respect, build trust, and actively collaborate in harmony with each other to meet individual client needs (Gilbert et al. 2000). By learning from each other in an interprofessional care setting, practitioners report understanding more than they had previously about their own practice and the practice of others (Oandasan and Reeves 2005; Xyrichis and Lowton 2008). Reports of improvement of health outcomes have been highlighted when practitioners and clients work together in this way (Nagelkerk et al. 2018; Myers Virtue et al. 2018). For example, Tippin, Maranzan and Mountain (2017) showcased an effective treatment for clients with chronic and comorbid mental health difficulties in outpatient community mental health settings in Canada utilising an interprofessional practice approach. Another example was provided by Lambeek et al. (2010) in the Netherlands. These researchers reported beneficial client outcomes for chronic low back pain following a randomised control trial in primary care settings utilising an interprofessional approach.

Despite the reported client benefits which drive further innovation in the interprofessional field, to be effective when adopting an interprofessional approach, practitioners are challenged to find ways to reduce hierarchies, change their

leadership structures, and enable multi-directional communication channels to emerge (Belasen 2014; Came and Griffith 2018). The need for these ongoing changes to their way of working can provide some practitioners with overwhelming demands in implementing an effective interprofessional approach in chronic care settings (Reeves, Goldman and Oandasan 2007). Barriers have been reported including the high turnover of staff, staff scepticism of interprofessional practice due to some negative interactions in rounding discussions (Hendricks et al. 2017), lack of co-location, and lack of access to direct communication pathways (Rich et al. 2020).

Furthermore, an interprofessional approach may not be possible in all chronic healthcare settings (Amalakuhan and Adams 2015; Cleary et al. 2019; Hall 2005). For example, Amalakuhan and Adams (2015) report that, while an interprofessional approach may improve outcomes for clients with chronic obstructive pulmonary disease, not all clients have access to the required resources for this approach (i.e., time, insurance, or access to trained practitioners in the nominated professions). As a result, the burden falls on their primary care practitioner to represent all of the roles required for the clients care while utilising inefficient networking with specialists for specific knowledge, making a deep collaboration with team members almost impossible.

Green and Johnson (2015) summarise this shift towards a more modern approach, at a time when many more people are living with complex and chronic health issues requiring increased involvement in health care,

> "*Times are changing, silos are falling, national health burdens are being shared, and it is going to take much more than a single practitioner or*

paradigm to solve the serious healthcare issues confronting humanity today and in the future" (p. 8).

While team-based practice is the way forward in many chronic care settings, the transformation from silos to teamwork cannot happen overnight. Deciding when to utilise an interprofessional practice approach and how to apply the various models that are possible within this field of practice must be primarily based on the needs of the client (Reeves et al. 2011). Therefore, an understanding of when an interprofessional approach can be most effective is paramount to advancing chronic care in the specific settings where this can have the most impact.

Practitioners have an obligation to promote their client's interests and ensure care provision is balanced in favour of doing good (beneficence) (Hafemeister and Spinos 2008; Mantel 2014; Rowe and Moodley 2013). Differing conceptions of wellbeing inform the beneficence of an intervention; one related to the client's view of benefit, and the other to an objective view by the health professional(s) of the activities that would benefit the client (Smith 2008). These two conceptions of wellbeing can create conflict between the practitioner's and the client's view of doing good, which needs to be weighed up and determined before developing interprofessional practice processes in the care setting, which may involve change for both the practitioners and the client.

Examining the beneficence of a particular care approach helps practitioners counterbalance the benefits and risks of different management strategies for clients. However, there is a paucity of literature on how practitioners determine the benefits and risks of an interprofessional practice approach (Firn et al. 2020; Oprea et al. 2010). To fill this knowledge gap, explorations of the experience of practitioners and

clients who have complex chronic needs in programs that include an interprofessional approach are vital.

This thesis aims to address this knowledge gap by exploring the clinical application of an interprofessional practice approach. The research will provide an understanding of the experience of practitioners and clients in an interprofessional program designed to meet complex needs of vulnerable clients – in this case, refugee and asylum seekers living with a complex chronic pain condition.

1.1 Why chronic healthcare needs an interprofessional approach

Chronic conditions are broadly defined as lasting more than three months and require ongoing healthcare services to improve a person's ability to interact in daily activities (Australian Chronic Disease Prevention Alliance 2020). The Australian healthcare system has many world-class aspects in terms of the range of services provided for people with chronic conditions (Calder et al. 2019; Dixit and Sambasivan 2018; Starfield 2000). Even so, the system struggles to prevent and manage chronic conditions effectively (Calder et al. 2019). The burden of chronic illness can be overwhelming for those who find it difficult to attend services or participate in self-management of their condition(s). Over 50% of Australians live with at least one ongoing health problem, and nine in every ten deaths are associated with chronic conditions (Australian Government Department of Health 2020; Pain Australia 2020). In 2017-18 the Australian Government (Australian Government Department of Health 2020) reported the most common chronic conditions, based on self-reported data, were mental health and behavioural complaints such as anxiety or feelings of depression (20.1%), followed by chronic back problems including ongoing pain (16.4%). In response to the needs of clients

with chronic health conditions, changes in healthcare delivery models, including the provision of services outside of acute hospital care, have grown in recent years.

As a consequence of rising long-term care needs (Malik et al. 2018), primary, community, and home-based healthcare (e.g. Broer, Koetsier and Mulder 2015; Cohen et al. 2016; Jorm 2018) now comprise the largest sector of the healthcare system. The focus of these services is providing care that helps develop sustainable self-management of their condition. Nevertheless, studies have shown that clients with long-term pain face several barriers when attending healthcare appointments. The issues caused by chronic pain, such as fatigue and physical disabilities, can create barriers for clients even after they navigate their way into a place in the healthcare system (Song et al. 2019). For example, clients may not be able to keep appointments due to fatigue and find it difficult to reschedule missed appointments promptly. Comorbidity is yet another hurdle, often increasing the already complex healthcare needs for some clients. In 2017-18 in Australia, more than 10% of people had two chronic conditions (comorbidity), while 8.7% had three or more chronic conditions (Australian Government Department of Health 2020). Chronic pain is often associated with comorbidities, such as depression and anxiety, by causal association (Tsang et al. 2008).

Ongoing pain can affect a person's emotional functioning, and thus their ability to cope with anger, anxiety and depression may also be compromised (Adams, Poole and Richardson 2006; McKellar, Clark and Shriner 2003). The treatment of individuals diagnosed with comorbidities can be complicated. People may be living with problems that include substance abuse, physical and mental health problems. The presence of comorbidities, such as these, often requires ongoing adjustments to

the client's medication use and self-management strategies to address potential relapse triggers (Piotrowski 2007). These ongoing adjustments may include physical therapy, along with pharmacologic management. Studies have recommended that people living with chronic pain should be managed by attending to the underlying psychological conditions for a meaningful recovery to be achieved (Garland et al. 2019; Miller, Forcehimes and Zweben 2019). Due to the complexity of chronic pain management, the International Society for the Study of Pain (2020) recommends using multiple therapeutic modalities to address these issues, such as medications and physical, rehabilitation, and psychological approaches. The recommended treatment often involves healthcare teams linked to the broader health system, mainly specialist services (e.g. drug management and behavioural treatment centres). These complex interconnections, both within and between health services, require collaborative approaches to practice (Greenstock et al. 2012).

Other barriers for clients with chronic pain conditions include challenges stemming from a cultural gap in providing adequate care (Floyd and Sakellariou 2017). For example, services that address language, isolation, poverty, and specialised needs are lacking in many communities (McKeary and Newbold 2010). Clients from culturally and linguistically diverse (CALD) cohorts, such as refugees and asylum seekers, may experience multiple barriers when navigating the healthcare system in a new setting (Floyd and Sakellariou 2017; Song et al. 2019; Taylor and Haintz 2018). These barriers include the need for language support (written and oral) and difficulties navigating the health system, in terms of access and care provision.

Bringing practitioner's together from different professions is not easy. A wide range of professional competencies and human dynamics need to be developed for teams

to practice collaboratively (Babiker et al. 2014; D'Amour et al. 2008; Nancarrow et al. 2013). These competencies include multi-directional communication (D'Amour et al. 2008), the sharing of responsibilities and accountability between team members (Nancarrow et al. 2013), clinical reflection (Mamede, Schmidt and Penaforte 2008), and conflict resolution (Del Valle and McDonnell 2018). Improving teamwork competencies across healthcare settings is an essential facilitator in driving effective teamwork practices and has garnered global research attention (e.g. Alle-Corliss and Alle-Corliss 2009; Ledlow and Coppola 2013; Penney 2013). The interprofessional practice field has developed to address these competency needs for teamwork involving practitioners from multiple professions.

The term '*interprofessional*' emerged from the United Kingdom during the 1960s and since then has become an important approach in healthcare (CAIPE 2002; World Health Organisation 2010). Interprofessional practice has been defined by the World Health Organisation (2010) as,

> "*Multiple health workers, from different professional backgrounds, providing comprehensive services by working with clients, their families, carers and communities to deliver the highest quality of care across settings*" (p. 13).

The World Health Organisation provided an imperative for interprofessional practice to strengthen the health workforce to meet these contemporary system challenges. For example, interprofessional practice aims to address gaps in client safety measures by enabling team members to advocate for clients across professions ensuring care plans are achievable, and medications are correctly adjusted for complex needs (Keene 2008). Interprofessional practice may also reduce

fragmentation of care by decreasing the need for multiple referrals, thus lessening the burden on health practitioners and clients (Cebul et al. 2008).

To enable benefits in healthcare settings, an interprofessional practice approach requires the cooperation of practitioners across multiple professions and between multiple practitioners and the client. The engagement of multiple practitioners in care has changed the delivery of services from mostly pre-arranged processes (pathways of care determined by client diagnosis irrespective of individual needs) to those requiring the active participation of clients and carers in designing and executing the service. D'Amour and Oandasan (2005) coined the phrase *'co-creation at the interface*' to capture the client's involvement in the multiple engagements with practitioners in interprofessional service delivery. The practitioners' capacity to communicate with each other and their clients have become vital in determining service delivery structure, placing demands on the practitioner's collaboration skills (D'Amour and Oandasan 2005; Spitzer, Silverman and Allen 2015; Stanhope et al. 2015). Co-creation and collaboration within healthcare delivery necessitate a shift in the relationships between clients and practitioners, which challenges both practitioners and clients' preparedness for these new types of health encounters.

In summary, interprofessional teams may offer an effective remedy to many of the challenges facing healthcare, from efficiency to safety and client engagement (Karam et al. 2018; Martin and Finn 2011; Mitchell et al. 2012). However, studies of healthcare teams offer a mixed picture of the success of teamwork competencies, illustrating the problems and challenges that accompany interprofessional practice in chronic care settings (Babiker et al. 2014; Körner et al. 2016).

1.2 Demands of an interprofessional approach

Interprofessional practice has values-based goals and works to support client engagement in shared decision-making (Joseph-Williams et al. 2017). However, few studies have examined the ethical deliberations, such as the development of mutual trust, relating to the change in the practitioner-client relationship of this approach compared to a client engaging with a practitioner in more siloed approaches to care. The therapeutic relationship depends on the unfolding of mutual trust (Spencer et al. 2019). Therefore, an ethical review of an interprofessional practice approach must be considered for its ability in developing this reciprocal commitment. For example, utilising an interprofessional approach that includes joint therapeutic sessions may change the relationship from a practitioner-client dyad to a practitioner-practitioner-client triad or an even more significant diversity of practitioners. Additional client support (carers, family, interpreters) may also be added to this triad. Consequently, the demands of the therapeutic relationship need to be considered in terms of their beneficence when adopting an interprofessional practice approach to care (Oprea et al. 2009).

One problem often experienced by practitioners in developing mutual trust with their clients is the need for culturally supportive and population-based treatments (Arnold et al. 2016; Bunn et al. 2018; Piotrowski 2007a). Definitions for health, illness and care vary by culture (Leininger and Reynolds 1991). For example, cultural awareness is paramount for practitioners in anticipating that the language related to health may vary with clients of different cultural backgrounds (Murray, Davidson and Schweitzer 2010). Practitioners must also be prepared to modify standard treatments (treatment shifting) to incorporate differing cultural beliefs. For example,

treatment shifting may need to occur when a client has a cultural belief around medication use (Nicholson and Verma 2004). Population-based treatments target the health and overall wellness of the broader population (Shahzad et al. 2019). The clinical characteristics of population-based treatments may include active strategies (e.g. correct posture exercising, modified use of social activities, actively strategies to reduce stress) and passive strategies (diet, avoiding activity, rest, medication). Culture may influence the clients use of population-based treatments by impacting an individual's perceptions of health, seeking help, and the types of treatments (active or passive) the client prefers (Adams and Drake 2006).

Cultural and population-based treatments can be more demanding for practitioners working with people who suffer from chronic pain, as many treatment options require a team-based approach. For example, studies that have included individuals with chronic pain have found multimodal approaches towards relieving pain, client participation in treatment, and improving self-efficacy help support chronic pain management (e.g. Brown and Richardson 2006; Slade et al. 2016; Ward 2020). Some of the effective strategies for managing chronic pain include pharmacotherapy, physical activity, social support, acupuncture, heating the affected area, rest, diets, and lifestyle changes for clients to manage their pain effectively (Takai et al. 2015). Together with an interprofessional practice approach to supporting pain management, this multimodal approach has been reported to be superior to standard pharmaceutical and invasive care treatments for chronic pain (Montgomery and McNamara 2016; Tompkins, Hobelmann and Compton 2017; Wren et al. 2019).

Client engagement in chronic pain management is key to building self-efficacy and the self-management skills needed for long term pain control (Jensen, Nielson and

Kerns 2003; Mann, LeFort and VanDenKerkhof 2013). In an interprofessional practice approach, cultural sensitivities can be even more pronounced, as cultural boundaries can exist between practitioners, as well between practitioners and clients (Pecukonis et al. 2008). Practitioners who adopt an interprofessional practice approach need to address cultural humility (a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's **culture**, but one starts with an examination of her/his own beliefs and **cultural** identities) (Tervalon and Murray-Garcia 1998) in their interactions with each other and with clients. However, this issue is not well addressed in the literature (Fisher-Borne, Cain and Martin 2015).

Paradis and Reeves (2010) examined the key trends in interprofessional practice research from 1970 to 2010. In an editorial based on this report and expert knowledge of the field, Reeves (2010) illuminated the need for studies that would examine behaviours between professions in practice, and studies that identified factors such as time, space, culture, and language that may affect these interactions. As a result, Reeves (2010) noted that understanding the nature of interactions between professions in practice was limited. Similarly, Reeves (2010) noted a lack of client perspectives concerning their experience of an interprofessional practice within care settings.

Six years later, Reeves (2016) revisited the empirical gaps in the field, highlighting the emergence of studies that had provided evidence of longer-term impacts of interprofessional practice (e.g. Semrau et al. 2015; Sytsma et al. 2015). Some success had also been gained using sociological perspectives to understand the impact of interprofessional practice in specific care settings (e.g. Goldman et al.

2016; Michalec and Hafferty 2015). However, despite progress made by the time of Reeves' 2016 editorial, identified gaps remained unaddressed in this field, such as understanding the nature of interprofessional work concerning the local needs of the care setting. Reeves worked with other researchers to conceptualise how nuanced knowledge in this area may benefit from targeted studies (Reeves and Lewin 2004; Reeves 2010; Reeves et al. 2018). Accordingly, these researchers proposed that a more contingent approach that better matches the design of interprofessional teams to their clinical purpose could be achieved if practitioners focused on meeting the individualised needs of clients. A focus on the client in this manner is known as *'client-centered care'* and is tightly coupled to the values of interprofessional practice.

Understanding client goals is often interpreted differently depending on the language used by practitioners to express their intentions. In particular, alongside client-centered care, two additional terms in the literature represent a holistic way of working between clients and practitioners; patient-centered care (e.g. Castro et al. 2016; Jayadevappa and Chhatre 2011; Hobbs 2009) and person-centered care (e.g. Edvardsson et al. 2010; Gabrielsson, Sävenstedt and Zingmark 2015; Kogan, Wilber and Mosqueda 2016). These terms are often used interchangeably with client-centered care. Nevertheless, Eklund et al. (2019) determined that patient-centered care is mainly focused on the person's functional life (immediate needs to be able to function) while person-centered care is focused on a meaningful life (longer-term goals). Eklund et al. (2019) compared reviews of person-centered and patient-centered care and determined five themes shared between these terms: empathy, respect, engagement, relationship, and communication. Furthermore, all five themes led to shared decision-making. The central concept between client, patient, or person-centered care, can therefore be seen as the importance of shared decision-

making as a central tenet of care. Supporting the client to engage in shared decision-making is one of the key goals of interprofessional practice, thus providing an explicit link between client-centered care and an interprofessional approach.

The Australian Commission on Safety and Quality in Healthcare (2019) defines client-centered care as:

> "*A foundation to safe, high-quality healthcare. It is care that is respectful of, and responsive to, the preferences, needs and values of the individual patient*." (p. 1).

Within this definition is the understanding that a person's care experience is influenced by how they are treated as a person and how they are treated for their condition (Australian Commission on Safety and Quality in Healthcare 2019). Sidani and Fox (2014) reviewed the interprofessional practice literature on client-centered care to explore which mechanisms may be essential. In this review, Sidani and Fox (2014) reported three specific elements - holistic, collaborative, and responsive care - to be incorporated in all definitions of client-centered care that link explicitly to the foundations of an interprofessional approach.

The first of these elements, holistic care, is often understood to be assessing clinical needs and providing a care plan that targets each of the client's conditions (Ackley and Ladwig 2010, Potter and Frisch 2007). A holistic framework of care puts the client's perceived requirements first and offers care not only for its therapeutic objectives but also for its ability to uplift the human spirit (Romeo 2000). Therefore, to be holistic, care must encompass an interpersonal relationship with the client built through interaction (Sulmasy 2002, Potter and Frisch 2007).

Collaborative care, the second element of client-centered care identified by Sidani and Fox (2014), is an approach designed to meet physical and mental health needs in an integrated manner. For example, Unützer et al. (2013) describe a collaborative care approach to integration in which primary care providers, care managers, and psychiatric consultants work together to provide care and support clients' progress while in group care facilities.

Responsive care is the third specific element identified by Sidani and Fox (2014) to be included in the definition of client-centered care. The term refers to the specific nature of client needs that are being addressed as part of the overall care plan, such as cultural aspects of care (Ring, Nyquist and Mitchell 2018), family aspects (Barczyk and Kredler 2018) or those of biological gender, such as responding to the biological factors affecting the health and development of women and girls (Meyer, Womack and Gibson 2016).

In addition to these three elements of client-centered care, the therapeutic relationship, the means by which a therapist and a client hope to engage with each other and effect beneficial change in the client (Dew and Bickman 2005) was identified by Sidani and Fox (2014) as a factor that facilitates client-centered care between practitioners and the client. This relationship develops over time as clients become more familiar with their practitioners and develop mutual trust. Through coming to know each other in therapeutic sessions, the relationship may involve other elements that practitioners need to manage together with the client, such as humour (Haydon, van der Reit and Browne 2015). Because of the need to manage conflicts with the client in the therapeutic relationship, practitioners need to learn to practice professional boundaries, that is the limits which protect a

worker's professional power and their client's vulnerability (Ollivier, Aston and Price 2019; Gabbard 2016). The therapeutic relationship is built on a nurturing and trusting alliance where practitioners and clients work with respect for each other. Furthermore, the development of mutual trust has been demonstrated to be predicated on client and practitioner alignment in the care goals (Orchard and Bainbridge 2016).

As a key goal of an interprofessional practice approach, shared decision-making requires the development of mutual trust and a therapeutic relationship between the practitioners and client, which often requires active support for client engagement in clinical sessions and treatment care planning (Légaré and Witteman 2013). Although practitioners rarely use the term themselves (Elwyn et al. 2000), they conceptualise what is termed '*equipoise*', which is a point in care planning when uncertainty leads to the need for a decision. At this time, the practitioners have no clear preference about the treatment choice in specific clinical scenarios (Dunn et al. 2018; Elwyn et al. 2000; Légaré et al. 2011). Equipoise is the point where practitioners report shared decision-making is most feasible (Légaré et al. 2011). Equipoise is not the same as the uncertainty that results from a lack of practitioner knowledge or experience. While variable levels of uncertainty exist at times in client care, expressing equipoise is the skill of portraying options in an open, non-directive manner that does not lead to client confusion, anxiety, or lack of confidence in the practitioner's ability (Elwyn et al. 2000). In some instances of equipoise, the decision will not be centered on treatment options but more positively focused on the attainment of '*eudaimonia*' for the client, or the ability to "*live life in a full and deeply satisfying way*" (Deci and Ryan 2006, p 36).

Within interprofessional teams, differing viewpoints amongst professionals within the team can arise regarding client care, which creates the need for shared decision-making between practitioners without the client's involvement, as a preparatory stage before providing the client with treatment options. This process requires the practitioners to develop an appreciation and value for the contribution of other professions on the team, which has been termed professional equipoise (Smith et al. 2015). Professional equipoise may occur as part of professional team meetings, in formalised communication, such as team care plans (e.g. Rapport et al. 2019), or part of informal discussions (e.g. Smith et al. 2015). The professional team meetings and other interprofessional team processes often require additional time away from practitioners direct clinical practice, which can be seen as a barrier in some settings (Körner et al. 2015). Nonetheless, the outcome of professional equipoise should allow teams to work more creatively and flexibly when actively involved in determining how to support clients in individual care activities (Smith et al. 2015). This type of preparatory work adds to the team's ability to collaborate with the client to encourage active engagement in the healthcare setting. Client engagement is a significant concern for practitioners within interprofessional teams as client-centered care and shared decision-making are reliant on interactive participation.

In order to develop a therapeutic relationship based on mutual trust, the practitioners in the interprofessional team need to engage clients with processes that include preparatory strategies, such as reducing perceptions that treatment will be too demanding or is not relevant (Nock and Ferriter 2005) and continuous strategies which provide ongoing knowledge and attitude support (Alnazly 2016; Isa et al. 2019; Luff et al. 2016). However, as outlined earlier, practitioners may need to support

clients utilising broad cultural competencies when developing engagement strategies (Arnold et al. 2016; Bunn et al. 2014; Piotrowski 2007). Clients may require treatments that fit within their beliefs and values and find it challenging to engage with care in an environment that does not show an understanding of their needs. Some studies have demonstrated that clients who have cultural backgrounds that differ from their practitioners can have positive outcomes with an interprofessional team approach (Korner et al. 2016; Oelke, Thurston and Arthur 2013). On the other hand, essential questions regarding the beneficence and non-maleficence of an interprofessional practice approach (Oprea et al. 2009) which require the client to develop mutual trust with multiple practitioners at the same time remain unanswered.

1.3 Engagement in specific care needs

Understanding how practitioners and clients come together to co-design healthcare requires a detailed study of the effects of engagement in client-centered care within local needs. That is a specific interprofessional approach in a specific healthcare setting with a specific client population. A focus on clients from refugee and asylum seeker background with complex chronic pain conditions offers a valuable cohort of clients and their practitioners for such a study as their refugee and asylum seeker background provides a homogenous population due to their shared experience.

The number of people seeking asylum and refuge is growing exponentially. In 2016 more than two million new applications for asylum were received globally, adding substantially to the total 70.8 million recognised (United Nations High Commissioner for Refugees 2018). People arriving in Australia in this way often have chronic health needs, including chronic pain (Harris and Zwar 2005). Indeed, Liedl and Knaevelsrud (2008) reported that 80% of clients from refugee and asylum seeker

background experience chronic pain. People of refugee and asylum seeker background face several obstacles for access to care as they have multiple cultural and language barriers and a high dropout rate due to their uncertain living conditions (Ghafoerkhana et al. 2019; Hartley et al. 2018). With the numbers of people from refugee and asylum seeker background growing worldwide, the need for evidence-based treatments tailored for this population is urgent (Ghafoerkhana et al. 2019; Nordbrandt et al. 2015; El Sount et al. 2019).

Few controlled trials have studied the efficacy of treatments targeting chronic pain for clients of refugee and asylum seeker background who also present with comorbidities of stress and anxiety, specifically survivors of trauma and torture (Moeller-Bertram, Keltner and Stringo 2012; Morina et al. 2012). For clients with mental distress who are from refugee and asylum seeker backgrounds, the need for a therapeutic approach that focuses on mental health may be contrary to their broader beliefs. Sheikh and Furnham (2000) have demonstrated how people from different cultures explain that mental distress can be tightly coupled to their broader cultural beliefs. The concept of supernatural and natural causes for mental distress is common in many societies (Landy 1977; Furnham et al. 1999) and differs between Western and non-Western backgrounds (White 1982; White and Marsella 1982; Kleinman 1987). This cultural context, in turn, can impact how people describe the causes of their own and other's behaviours and the presentation of their condition.

Furthermore, cultural context can often influence refugee and asylum seeker patterns of help-seeking. For example, clients from the Indo-subcontinent tend to favour a '*scientific*' approach to help-seeking (Ramesh and Hyma 1981). This approach differs from clients of Asian descent residing in the United Kingdom who

are reluctant to seek psychological help (e.g. Cochrane and Stopes-Roe 1981; Rack 1982; Currer and Stacey 1986). Therefore, any approach to care for clients with mental health distress needs to include understanding their cultural differences and ways of discussing their distress to ensure appropriate treatments are part of their care plan (Gilgen et al. 2005). Few studies have tried to assess the help-seeking attitudes of clients with physical and mental health conditions such as complex chronic pain associated with conditions of stress and anxiety due to trauma and torture (e.g. De Leo et al. 2005). However, physical pain is one of the most common and compelling reasons for seeking medical attention (Gureje et al. 1998; Hartvigsen et al. 2018). In Australia, primary care (e.g. care provided by community health centres), provides a *'no wrong door'* policy to help alleviate the cultural differences clients may have in seeking help for conditions that include the need for mental health support (McGorry et al. 2014; Rickwood et al. 2019).

1.4 Meeting local need

A team of practitioners at cohealth[1], a community health centre in Melbourne, Australia, recognised a pattern emerging with several clients from a refugee and asylum seeker background who experienced chronic pain, anxiety, and stress. Practitioners observed that these clients were *'bouncing around'* in the services offered by the health centre. These clients were referred to physiotherapists for chronic pain, where they were recognised as needing mental health support, and then referred to the counselling service, who then identified a need for physical pain

[1] cohealth utilises a lowercase 'c' in all versions of naming of this centre to provide an inclusive, non-hierarchical attitude. Therefore, in this thesis, the name will also appear with a lower 'c'.

therapy for their pain. This cycle of referrals occurred over time without resolving their holistic healthcare needs.

A model of care that included an interprofessional practice approach was proposed to help avoid this referral merry-go-round while also addressing culturally appropriate support with these clients (cohealth 2014). This approach has, at its core, an initial joint therapeutic session with two practitioners from different professions (physical and psychological support). Practitioner's work together with the client to develop a narrative of the client's unique experience and specific needs in developing self-efficacy in managing their chronic pain.

The research described in this thesis accompanies the clinical program developed by the practitioners at cohealth. This study explored the experiences of practitioners and clients who participated in an interprofessional practice care setting with clients who have complex chronic needs. The clients who participated in the study are of refugee and asylum seeker background experiencing complex chronic pain, stress, and anxiety. The practitioners who participated were experienced in their profession (a minimum of two years' experience in their field) from physiotherapy, counselling, exercise physiology, nursing, and remedial massage. The setting is the cohealth community health centre in Melbourne, from 2015 to 2020.

1.7 Insights and significance of the research

This research will provide insights into the experiences of practitioners and clients who took part in joint therapeutic sessions as part of a care setting that included an interprofessional practice approach. The IPA included in this thesis will help to illuminate shared themes within the experiences of the practitioners. These themes

will then be triangulated using multiple views of the same phenomenon for validation and exploration of concepts with a view of the phenomenon from the client's perspectives. These insights may help organisations understand ways to support practitioners in strengthening their interprofessional practices, support practitioners in working in care settings that utilise an interprofessional approach and identification of client needs based on their experience of an interprofessional approach. This study will also offer insights into practitioner engagement strategies for working together in joint therapeutic sessions and mechanisms for supporting clients in this type of interprofessional approach. Few studies have included the client's experiences of being part of an interprofessional practice team approach. These insights will contribute to the growing body of literature on clients with comorbidities, specifically chronic pain.

1.8 Structure of the thesis

The prologue and this chapter have introduced the research documented in this thesis. Chapter Two presents a review of the literature in the four domains of concern for this study: interprofessional practice, client-centered care, community healthcare in Australia, and the issues that we understand about healthcare complexity for clients of refugee and asylum seeker background. Each domain of the literature review concludes with details of what researchers are promoting as the most critical research objectives in these areas and how this study addresses these areas. Chapter Three introduces the chosen research strategy and the philosophy of phenomenology. The chapter includes the history and development of an IPA approach. Chapter Four provides the detailed methods undertaken during the research, including selecting and recruiting participants, data collection, analysis,

and determinations of rigour and trustworthiness. Chapters Five and Six showcase the findings of the research. Chapter Five provides the results and interpretative analysis from the practitioner's perspective, while Chapter Six provides the client perspectives. These two chapters present the first and second parts of the lived experience dyad. Chapter Seven is a discussion of the findings of this study. This chapter explores the themes illuminated in Chapter Five of how the practitioners made sense of their interactions with each other in the interprofessional team. The discussion then expounds on the main themes developed from the practitioners and client's interviews in Chapters Five and Six. It examines the interactions of these multi-perspectival views of the phenomenon of an interprofessional practice approach in this care setting. Finally, the discussion provides a critique of the study's strengths and limitations, together with suggestions for clinical practice and further research. Reflexivity of the study is provided to conclude the thesis.

Chapter Two: Review of the literature

This chapter explores the domains of interprofessional practice, client-centered care, community healthcare, and the issues we understand about healthcare complexity for clients of refugee and asylum seeker background. Within each of these domains, the literature is assessed for what is known and not known concerning the research questions raised in Chapter One. The chapter concludes by positioning the need for this research.

2.1 What is interprofessional practice?

The term '*interprofessional practice'* is often met with curiosity by practitioners in healthcare who have not been exposed to this terminology during their pre-licensure or post-licensure practice. It is not a term used freely in everyday language of health practitioners in clinical practice, so it brings a need for clarification. The definition of

interprofessional practice provided by the World Health Organisation (2010) as provided in Chapter One, does not differentiate interprofessional practice from other forms of team-based care, such as multidisciplinary, intradisciplinary or transdisciplinary teamwork.

Practitioners working in these different forms of teamwork aim to deliver quality care by having multiple professions involved in the care of the client. The distinction between these forms of teamwork becomes essential when, for example, practitioners are aiming to address the impact of an interprofessional approach. A general problem in the field of interprofessional practice is a paucity in the literature of studies aimed at understanding the benefits of this approach in specific care settings (Busari, Moll and Duits 2017; Oprea et al. 2009). In particular, studies are explicitly lacking in care settings where the demands of the practitioner-client interaction have created a change in the nature of the therapeutic relationship.

To critique the impact of an interprofessional practice approach on practitioners and clients requires an in-depth understanding of precisely what this approach is and what it is not compared with any other healthcare approach. To address this lack of clarity of the nature of interprofessional practice compared to other forms of teamwork, examining the experience of interprofessional practice from various points of view to tease out its unique properties is required. This review will therefore examine the historicity of the term '*interprofessional*', when an interprofessional practice approach is utilised, what benefits this approach may bring, what the models are for working in this way, what mechanisms are used, and what types of leadership are encouraged. In addition, this review will examine studies that have sought to illuminate the spirit (essence) of an interprofessional approach. This review aims to

answer the question – '*what distinguishes interprofessional practice from other forms of team-based healthcare?*'

2.1.1 Going back to where it all began, a brief history of team-based practice

Using a team-based approach to healthcare is generally considered to have been conceptualised in 1948 by Martin Cherkasky at the Montefiore Hospital in New York City (Kindig 1975). While Cherkasky's efforts are noted as the earliest record of what we now consider to be '*primary care interprofessional teams'*, Royer (1978) notes that before 1900, mission hospitals in India utilised health care teams in outreach programs to remote communities. The Dawson Report (1920) in Great Britain also documents a '*team approach'* to care and the establishment of '*health centres'*, which were integral to healthcare in London in the 1920s, espoused as a '*positive health model'* (Pearce and Crocker 1943). This new model was noted as the inspiration for the concept of primary health teams in the late 1940s and provided the foundation for the earliest records of a community-based health program developed in 1950 by Sidney Kark and colleagues (Kark 1951).

During these early years, particularly those years directly following World War II, the term '*multidisciplinary*' was used to refer to these clinical teams (D'Avray 2007). The term '*interdisciplinary'* appeared in the mid-1960s (St Clair and Hough 1992). This change in terminology coincided with the move in the US to provide a greater reach of health services to the poor and underserved through community health centres. The term interdisciplinary was used to espouse the idea that the team composition was based on professions (e.g. medicine, nursing) with different skills coming together to meet the needs of the client. DeWitt C. (Bud) Baldwin Jr., a pioneer of

modern team-based practice, in an interview with D'Avray (2007), explained that as these interdisciplinary teams were located in the community away from the mainstream hospital care system, they were more egalitarian and less hierarchical. The term interdisciplinary became synonymous with the new egalitarian structure of the relationships inherent in these community team structures and was later applied to university education, which grew to support health profession students to work in team-based care (Baldwin 2007).

By 1972 interdisciplinary health care teams had become well known for meeting complex client needs in community care. The Institute of Medicine in the US (1972) called for team-based client care to improve client outcomes and safety, demonstrating that a team approach had made its way into the more mainstream hospital-based health care system (Blue, Brandt and Schmitt 2010). In 1975, Rosalie Kane introduced the two terms that are still in use today, '*interprofessional*' and '*teamwork*'. Their different goals demarcated the terms interdisciplinary and interprofessional. The term interdisciplinary encompasses aligning resources in educational endeavours, while the term interprofessional aspires that professionals offer their unique disciplinary knowledge for service to clients (Parse 2014). The term teamwork also highlights the work done by practitioners in working together rather than the actual manual work being undertaken. Therefore, in introducing these two terms together – interprofessional and teamwork – Kane was emphasising the efforts of the interaction of the practitioners in working together for the benefit of the client.

James Hill Barber, a medical physician, and Barbara Kratz, a senior nurse, collaborated to publish one of the first books on interprofessional practice in 1980

entitled '*Towards Team Care'* (Barber and Kratz 1980). This publication highlighted the roles and responsibilities of members of interprofessional care teams and some of the difficulties inherent when professions are brought together in this way. Shortly afterwards, the UK's Centre for the Advancement of Interprofessional Education (CAIPE) was formed in 1985 to bring the interprofessional community together to enhance research and develop a structured education base (CAIPE 2012). CAIPE has remained a Centre of Excellence for interprofessional practice, reinforced by its launch of the *Journal of Interprofessional Care.* In addition, CAIPE provides support for international conferences (e.g. '*All Together Better Health'*, and '*Collaboration Across Borders'*), which have focused on showcasing high-quality research and exemplars of practice. Many other countries have since established national centres which follow the guidelines of CAIPE. For example, the Australian Interprofessional Practice and Education Network (AIPPEN) was launched in 2006 based on the CAIPE model.

Defining the term interprofessional

As mentioned previously, interprofessional practice is a term that is often used interchangeably with the terms '*multidisciplinary*' and '*transdisciplinary*' but has a distinct point of difference from each of these other types of team-based work in healthcare. As has been shown through the history of the term, interprofessional practice carries the values of interprofessional education and the team-based competencies required to work in this manner. In contrast, a multidisciplinary team is defined by Saint Pierre, Herskovic and Sepulveda (2018) as,

> "*A group of professionals from two or more disciplines who work on the same project, independently or in parallel*" (p. 132).

Therefore, the distinction between interprofessional and multidisciplinary teamwork is in the collaborative nature of the interaction of the professionals, where multidisciplinary teamwork has professionals working independently or in parallel and interprofessional teamwork has practitioners working in collaboration (Flores-Sandoval et al. 2021)

Transdisciplinary teamwork is also clearly demarcated from interdisciplinary teamwork by a difference in the allocation of roles and responsibilities provided to team members. Transdisciplinary teamwork is defined by Vogel et al. (2014) as,

> "A*n integrative process whereby scholars and practitioners from both academic disciplines and non-academic fields work jointly to develop and use novel conceptual and methodological approaches that* synthesize and extend *discipline specific perspectives, theories, methods, and translational strategies to yield innovative solutions to particular scientific and societal problems*" (p. 3).

This definition highlights the goals to synthesise approaches from the contributing disciplines and extend beyond these origins to produce new approaches to solving complex health issues (Vogel et al. 2014). Therefore, interdisciplinary teamwork encompasses not only role blurring across disciplines, but a transformation of individual roles and responsibilities to newly created roles that blend multiple disciplines.

In comparison, some role blurring may occur within an interprofessional team, but this is limited in nature and defined by Sims, Hewitt and Harris (2015) as,

> "*While professional roles are clearly defined, a shared body of knowledge and skill between team members means some elements of other professionals' roles can be taken on by others if needed. This overlapping or 'blurring' of roles helps ensure the carry-over of skills in the absence of particular disciplines. It can aid team members' professional development by enabling them to gain a greater range of expertise and can lead to greater continuity of patient care*" (p. 23).

Therefore, these two types of healthcare team approaches are demarcated by the distinction between the intentional skills based '*role blurring'* in interprofessional practice and combining disciplines to create a '*new discipline'* in transdisciplinary practice.

For the remainder of this thesis, the term interprofessional will be used to capture the distinguishing features of this approach: interprofessional values, team-based competencies, and the collaborative nature of the interaction between professions. However, our understanding of interprofessional practice is not complete until we consider when and why it is utilised and how it is conceptualised in practice.

2.1.2 When and why is an interprofessional practice approach utilised

Interprofessional practice has been called on by the World Health Organisation (WHO) as an imperative to strengthen the health workforce to meet the increase in complexity and multifaceted needs of people with chronic health problems (Lueddeke 2015; Reeves et al. 2011; World Health Organisation 2010, 2013). Several benefits of interprofessional practice have been reported, such as reducing fragmentation of care (D'Amour and Oandasan 2005), increasing and broadening

individual skills for practitioners (Reeves et al. 2016), and providing practitioners with active support in complex care (Shaw 2008).

Each of these benefits has broad-reaching implications for improving health care services. For example, fragmentation of care often occurs with clients who have complex chronic musculoskeletal pain (Ryan et al. 2007). These clients are referred to multiple specialist services within the healthcare system, services that are not connected. Clients can experience long wait times for symptom assessment (e.g. Nelson and Wilson 2018). Interprofessional practice aims to connect services to ensure clients are assessed holistically and to reduce overuse, misuse, and long delays in service delivery.

Another benefit of interprofessional practice is that it provides practitioners with the opportunity to work alongside other professions, learning with, from and about each other, often in complex case management. These learning opportunities provide benefits such as understanding different perspectives of client care, and what information is essential for practitioners in different professions to learn from clients to enable them to assess a problem from the perspective of their profession. These benefits are important for individual practitioners, the organisation, and the clients who are the recipients of care from teams with more significant experience (e.g. Farrell et al. 2013).

A further benefit of interprofessional practice is the support practitioners provide to each other when negotiating complex case treatment decisions (Anderson et al. 2017; Parker et al. 2013). Interprofessional team meetings are particularly beneficial in providing support as practitioners can discuss options with each other, resolve

conflicts, and receive feedback while focusing on the holistic needs of the client (Xyrichis and Lowton 2008).

Another benefit of an interprofessional practice approach may be in minimising adverse events for clients. Reducing medical errors is vital for client safety. The World Health Organisation (2014) reported that most adverse events are caused by miscommunication between team members and misunderstandings of team roles and responsibilities. Incidents that harm clients attributed to the healthcare system are estimated to occur in 10% of all hospital admissions globally (Runciman, Merry and Walton 2007). In Australia, reports indicate that 18,000 Australian clients die, and 50,000 clients suffer disabilities annually due to adverse events. Adverse events causing disabilities are also associated with poor communication and inadequate teamwork (Braithwaite et al. 2007). Additionally, poor communication between practitioners and clients has emerged as a common reason for clients taking legal action against healthcare providers (Vermeir et al. 2015). Interprofessional practice competencies are designed to build a healthcare model that reduces medical errors and adverse outcomes. Therefore, Interprofessional practice may improve the quality of care for clients by reducing medical errors (Lown et al. 2016).

Another quality issue addressed by interprofessional practice is the treatment burden for clients. Treatment burden is the term used to describe a negative experience resulting from healthcare. This burden is distinct from the burden of illness which refers to the impact having a chronic disease may impose on the individual (Sav et al. 2013). Reports have linked treatment burden with poor adherence to medications, lower satisfaction with care, and decreased quality of life (Sidorkiewicz

et al. 2016; Tran et al. 2014). Additionally, treatment burden has been linked to ineffective use of health resources (Sav et al. 2013, 2015). The healthcare system contributes to this burden through poor coordination of healthcare services, incomplete communication between practitioners, and misaligned practitioner-client relationships (Eton et al. 2012; Moss and Crane 2010). Interprofessional practice aims to reduce treatment burden by working with clients to understand and address their needs holistically. Understanding client needs includes their values and beliefs, social structure, and other demands on their daily lives when designing the best plan to manage their burden of illness. It is not surprising that meeting complex client needs has emerged as one of the main drivers for implementing an interprofessional practice approach in chronic healthcare.

In 2018, Reeves, Xyrichis and Zwarenstein connected disparate concepts of practitioners working together into a singular, contingent approach to defining interprofessional practice, which they named the InterPACT model (Reeves et al. 2018; Xyrichis et al. 2018). The InterPACT tool, is based on the typologies of interprofessional work activities, further expanded in Table 2.1. The authors proposed definitions of four types of team practice, networking, coordination, collaboration, and teamwork. Reeves et al. (2018) stressed that these four types are not stronger or weaker than each other, nor are they less or better forms of teamwork practice. They conceptualised each team would develop an interprofessional practice approach that may differ in form and function depending on clinical needs and organisational abilities to meet these needs while always remaining client-focused.

Table 2.1 Typology of interprofessional work activities (Xyrichis et al. 2018) (Reprinted with permission)

Teamwork	Collaboration		Coordination			Networking
	Consultative collaboration	Collaborative partnership	Coordinated collaboration	Delegative coordination	Consultative coordination	
Teamwork encompasses a number of core elements including, but not restricted to, a high level of shared team identity, clarity, interdependence, integration and shared responsibility. Examples of this type of interprofessional work can include family	A sub-category of collaboration, characterised by a predominantly consultancy function from a collaborative team to other clinical, patient or management	A sub-category denoting a collaborative type of working restricted to just two kinds of professions, rather than a wider interprofessional team.	Sub-category denoting a team with both a collaborative and coordination component, of which the latter is more prominent.	Sub-category of a coordinated team involving a large component of delegation in its decisions or actions.	Sub-category of coordination in which the team performs a predominantly consultative function to other clinicians or management groups.	A networking relationship is one in which shared team identity, clarity of roles/ goals, interdependence, integration, and shared responsibility are less essential. Networks can be virtual, in the sense that none of the members meet face-to-face but communicate in an

practice and emergency department/room teams.	groups/ individuals.					asynchronous manner by use of the Internet (e.g. email or computer conferencing). Examples of this type of interprofessional work include networks of clinicians who meet to discuss or share information/clinical guidelines across a number of institutions.

Xyrichis et al. (2018) suggest the InterPACT model should be useful as a diagnostic self-assessment tool to classify types of interprofessional teamwork. The author's aim in developing the InterPACT tool, shown in Figure 2.1, was to foster an understanding of how differing but interconnected interprofessional studies could be brought together to facilitate further research on this topic. A consistent terminology within the interprofessional field may also support accountability and clarity in research reports.

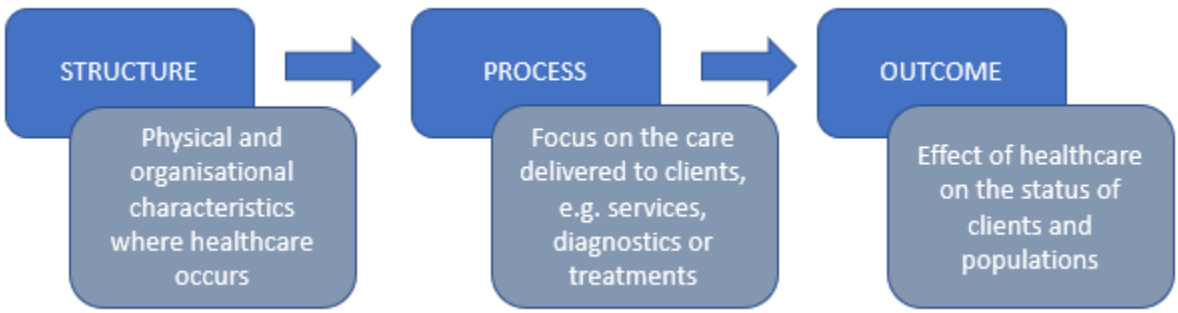
Figure 2.1 InterPACT tool. Developed by Xyrichis et al. 2018 (Reprinted with permission)

	Dimensions of interprofessional activity					
Kinds of interprofessional activity	Shared commitment	Shared identity	Clear team goals	Clear roles and responsibilities	Interdependence between team members	Integration between work practices
Teamwork	⊕⊕⊕⊕	⊕⊕⊕⊕	⊕⊕⊕⊕	⊕⊕⊕⊕	⊕⊕⊕⊕	⊕⊕⊕⊕
Collaboration	⊕⊕⊕⊕	⊕⊕⊕	⊕⊕⊕	⊕⊕⊕	⊕⊕⊕	⊕⊕⊕
Consultative Collaboration	⊕⊕⊕⊕	⊕⊕⊕	⊕⊕⊕	⊕⊕⊕	⊕⊕	⊕⊕
Collaborative Partnership	⊕⊕⊕⊕	⊕⊕⊕	⊕⊕⊕	⊕⊕⊕	⊕	⊕⊕
Coordination	⊕⊕⊕	⊕⊕⊕	⊕⊕⊕	⊕⊕	⊕⊕	⊕⊕
Coordinated Collaboration	⊕⊕⊕	⊕⊕⊕	⊕⊕⊕	⊕⊕	⊕	⊕
Delegative Coordination	⊕⊕	⊕⊕	⊕⊕⊕	⊕⊕	⊕	⊕
Consultative Coordination	⊕⊕	⊕⊕	⊕⊕⊕	⊕⊕	-	⊕
Networking	⊕⊕	⊕⊕	⊕⊕	⊕	⊕	⊕

2.1.3 Models of interprofessional practice

Establishing a model of practice for interprofessional teams is essential for planning and implementing new services. Understanding the model used as a framework for clinical processes also helps in the assessment of the team's effectiveness and the services they deliver. To enable an effective interprofessional practice approach the environment (context) needs to be considered. The key factors included in decisions to establish processes important for interprofessional practice made by the organisational managers of a healthcare centre are those that direct the coordination and collaboration of the healthcare team. For this reason, the structure-process-outcome model (Donabedian, 1988) has often been used to help guide the processes of an interprofessional practice approach because this model allows the focus of the processes to be determined by the structure of the healthcare setting, and the intended outcomes for the clients receiving care. This model is shown in Figure 2.2.

Figure 2.2 The Donabedian model for quality of care (adapted from Ayanian and Markel 2016)



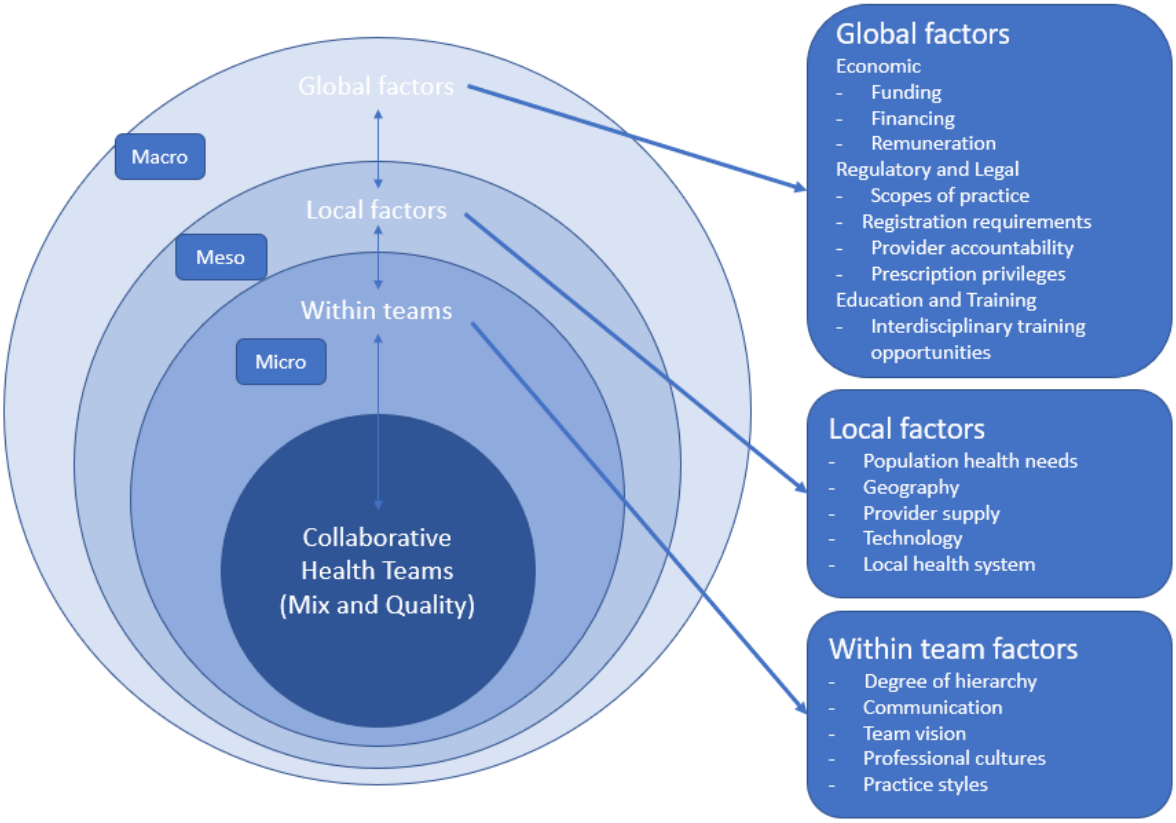
The poet and scholar Avedis Donabedian published the structure-process-outcome model as a means for assessing quality in healthcare that includes the performance of practitioners as well as the contribution of clients (Donabedian 1988). Radical in his thinking, Donabedian believed improvements in clinical outcomes are not necessarily the best measure of quality. Instead, he argued that the process of the care itself needs to be examined. Donabedian (1988) believed that healthcare outcomes reflect the set of conditions that have been applied in the context under study. In healthcare, conditions include the ability to achieve results and the degree to which participants' actions contribute to the results. The structure-process-outcomes model is a way of understanding the care setting in which healthcare interactions take place.

The structure level of the Donabedian model describes the context of the buildings, staff, financing, and equipment that shape the care being delivered. The process level describes the relationships, coordination, and collaboration between the practitioners in the care team. In comparison, the outcomes level refers to the effect of healthcare on the clients. This model has been useful in many studies of interprofessional teamwork to help develop frameworks for assessment (e.g. Dumont et al. 2010; Tomizawa, Shigeta and Reeves 2017; Willumsen, Ahgren and Odegard 2012), and evaluating the quality of care (e.g. Fabbruzzo-Cota et al. 2016; Baik and Zierler 2019; Reeves et al. 2011).

However, what was missing from the Donabedian model of interprofessional practice was the bi-directional influence of the global factors and local context on the team processes. Therefore, the Donabedian model was advanced by Mulvale and Bourgeault (2007) as shown in Figure 2.3. These researchers published a

conceptual framework based on a review of the academic and policy literature to help understand the factors that influence interprofessional collaborative mental health.

Figure 2.3 Conceptual framework of collaborative healthcare (adapted from Mulvale and Bourgeault 2007).

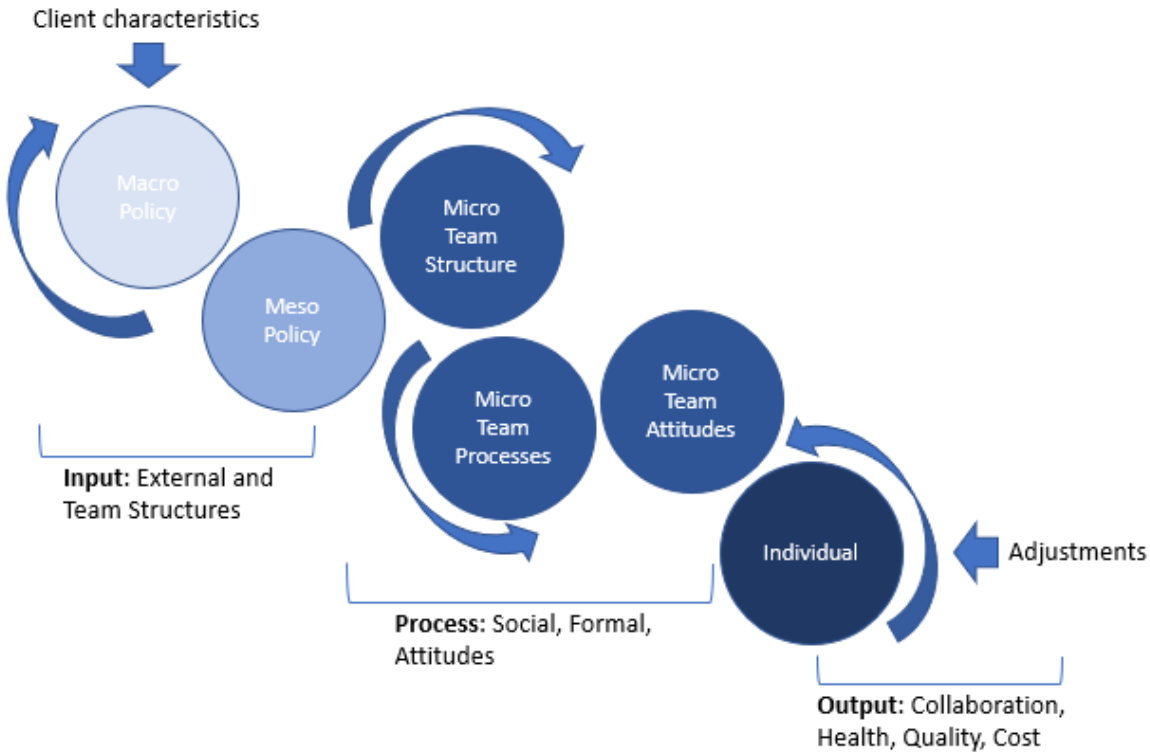


The Mulvale and Bourgeault (2007) framework utilised the structure-process-output ideas of the Donabedian model, but included interacting factors on a macro, meso and micro level. The concentric rings that form the structure of the framework represent the global level (macro) of policies that affect all health programs at the outer ring, then the local level (meso) that affects organisations and team characteristics, and lastly, the local context (micro), and individual characteristics. This model is different from the Donabedian model in that it

portrays the influence of factors from one ring to the next. Together the factors shape the quality of collaboration shown in the centre of the circles.

However, following further investigation of how the Mulvale and Bourgeault (2007) model could be applied in clinical studies, Mulvale, Embett and Razavi (2016) developed a refined version of this model. This new framework, termed the Gears Model, incorporates the interaction and bi-directional influences of structure, process, and attitudes at the micro level, as well as policy level influences at both the macro and meso levels. The Gears Model is shown in Figure 2.4.

Figure 2.4 The Gears Model (adapted from Mulvale, Embrett and Razavi 2016)



This new model is dynamic and integrates three concepts; (i) the Donabedian model, (ii) the macro-meso-micro-individual model introduced in 2007, and (iii) the fluid nature of the healthcare environment which continually shifts depending on the relationships between participants. A series of gears represent the factors that

work with each other to determine the collaborative performance of the team. Mulvale et al. (2016) envisioned that the result of the interactivity of the gears contributes to the program outcomes in terms of client health outcomes and quality of care. This distinction is important because it encompasses the idea that the client characteristics and outcomes are partly responsible for shaping the outcomes at the nexus of the practitioner and client interactions. The structure of the interprofessional practice approach is also essential for understanding how the client interacts with the practitioners in the team. The different approaches to an interprofessional practice program are outlined in the next section.

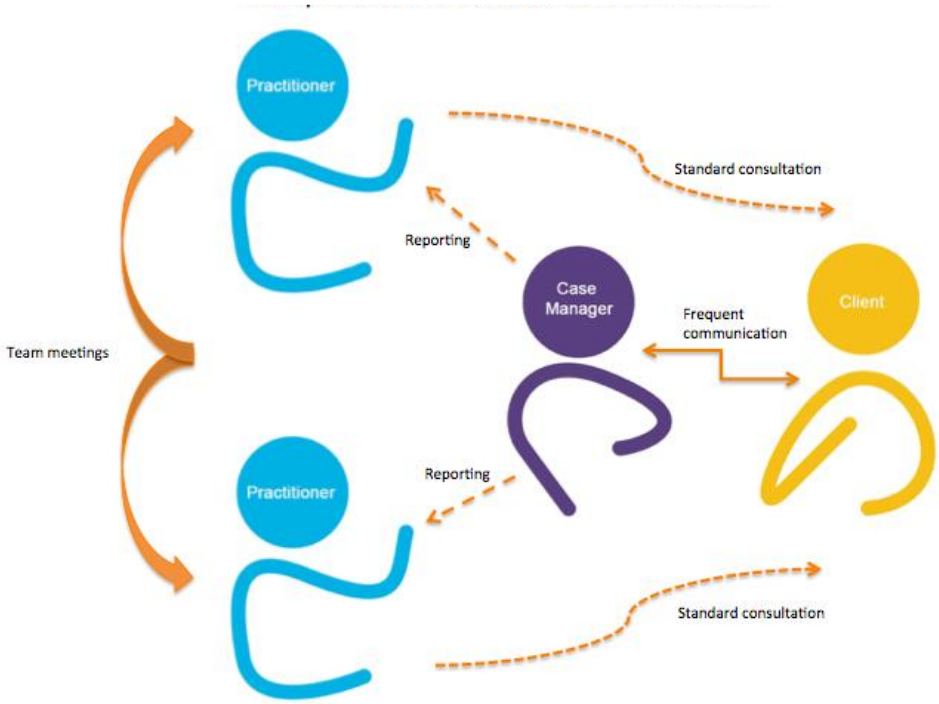
2.1.4 Structures of an interprofessional practice approach

Several different interprofessional approaches are identified in the literature, such as collaborative care, care pathways, group care and joint therapeutic care, and several interprofessional interventions. The client's involvement in each of these approaches to interprofessional practice is multidimensional: they can be regarded both as a team member and as the recipient of its services (Thistlewaite 2008).

Collaborative care is one of the most highly reported interprofessional approaches to care, with several large research trials across the US, UK, and Australia (e.g. Coventry et al. 2015; Schlicht et al. 2013; Unützer et al. 2013). The Collaborative Care model is defined as a multifaceted organisational intervention that includes the introduction of case managers as mechanisms to improve liaison between primary care practitioners and mental health specialists and systems to manage information on individual client progress (Bower et al. 2006). Utilising a Collaborative Care model has been demonstrated to improve client outcomes in

cohorts of clients with mental and physical multi-morbidity in academic and research-focused trials and more routine settings (Coventry et al. 2014). Figure 2.5 shows the typical interactions undertaken in this approach, including frequent communication between the client and the Case Manager, reporting functions between the Case Manager and the multiple practitioners, and team meetings between the practitioners.

Figure 2.5: Interprofessional Collaborative Care Model



Utilising a Collaborative Care model, the Case Manager may be, for example, a trained registered nurse or psychological wellbeing practitioner (graduates or ancillary staff) (e.g. Coventry et al. 2014). The Case Manager undertakes a substantial assessment with the client and reports this information to the practitioner prior to a standard consultation between the practitioner and client. In this way, the practitioner has more detailed background information than would have been possible to obtain in a usual care session, which can be incorporated

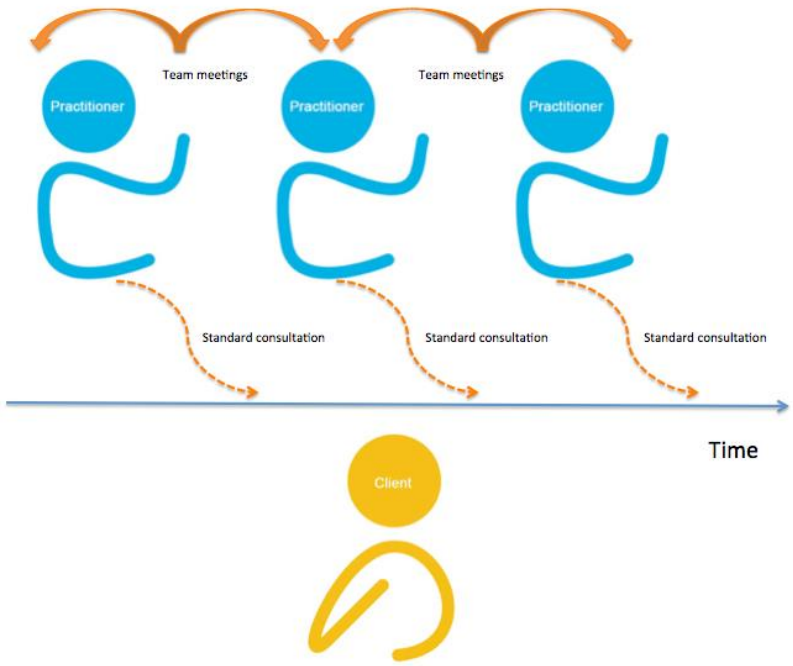
into a long-term plan. The case manager is responsible for follow up activities with the client. The reported benefits of this model are: (a) maximises the practitioner time with the client, (b) the practitioner has more information available about the client to use in a care plan, (c) the client feels listened to and adds information to the overall care plan, (d) the case manager follows up and helps the client with adherence to the care plan.

In comparison to the Collaborative Care model, an interprofessional pathway model does not have a Case Manager. The interprofessional pathway care model was first defined by the Chair of the European Pathway Association (E-P-A) Professor Vanhaecht as,

> **"***A complex intervention for the mutual decision-making and organization of care for a well-defined group of patients during a well-defined period***"** (Vanhaecht et al. 2010, p. 52).

Care pathways are widely used as quality improvement strategies for organizing and reorganizing care processes (Vanhaecht et al., 2006). The benefits of using a care pathway model include (a) supporting healthcare teams implementing evidence based key interventions and reducing clinical variations in every day practice (Panella, Marchisio and Di Stanislao 2003), and (b) as high-performing work systems that improve organisational performance by strengthening relationships and coordination among team members (Gittell 2002; Gittell, Seidner and Wimbush 2010). Interprofessional care pathways have been reported to enhance teamwork and improve staff knowledge, communication, documentation and interprofessional relations (Scaria 2016). Figure 2.6 depicts the interactions of the client and practitioners in a simple interprofessional care pathway.

Figure 2.6: Interprofessional Pathway Care Model

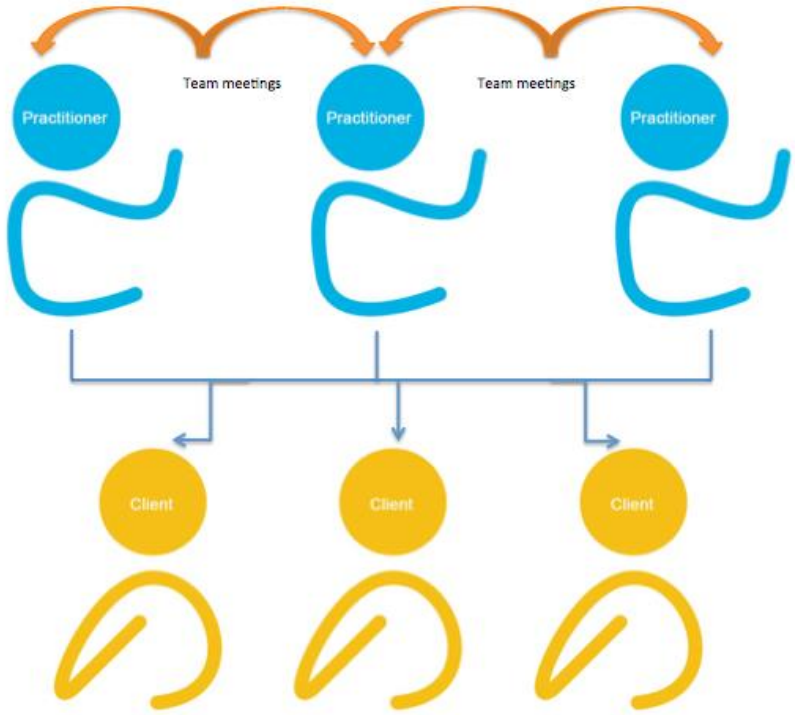


Utilising an interprofessional care pathway approach, the client interaction is on a one-to-one basis with the practitioners who may change over time depending on the needs of the client. The most common interprofessional care pathways reported in the literature are ones for clients in stroke care (Cramm and Nieboer 2011; Harris et al. 2013) and oncology care (Colyer 2011; Sohi, Peckham and Mott-Coles 2018) both following a similar pattern of acute incident (stroke or cancer diagnosis) likely to require a hospital stay, followed by an orchestrated care pathway of selected practitioners who coordinate the clients care plan.

Another common approach is the interprofessional group care model utilised to support healthcare needs such as chronic pain, obesity, aged care, home care, day care hospice, and hospital rehabilitation. Group interventions are expected to heighten a shared sense of social identification among participants and encourage productive social engagement, both factors that have previously been shown to

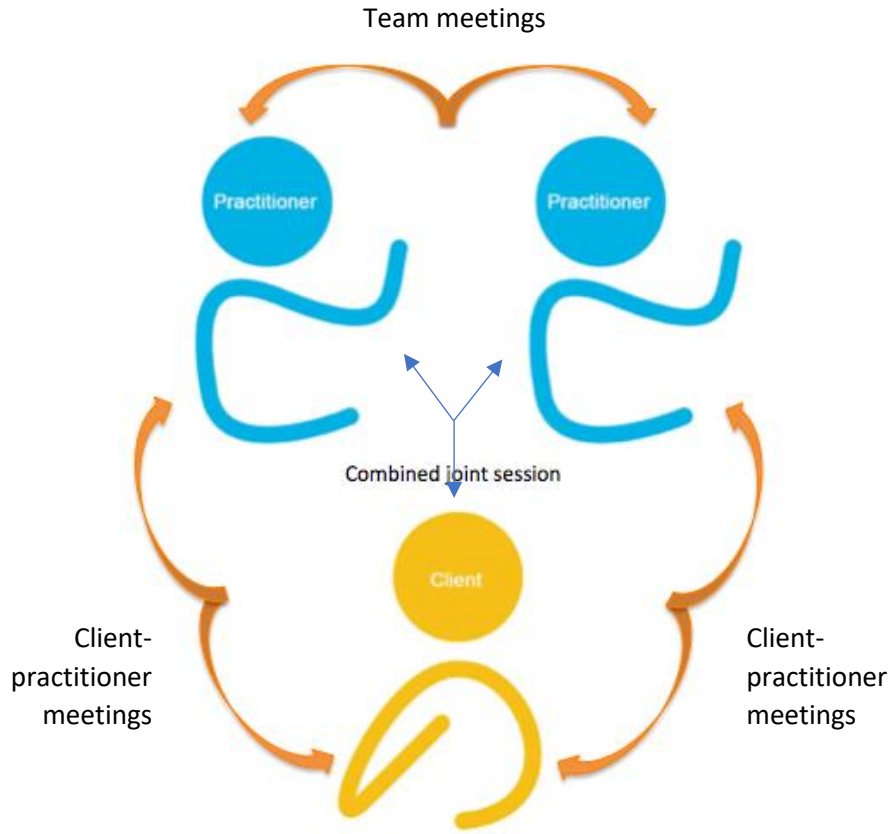
contribute to a range of positive health-related outcomes (e.g., Haslam et al. 2009; Tyler and Blader 2003). Figure 2.7 shows the interaction of participants in an interprofessional group care model where practitioners meet with clients in a group or individually and meet with each other as a team.

Figure 2.7: Interprofessional Group Care Model



Another model of an interprofessional practice approach is the interprofessional joint therapeutic care model. The joint therapeutic care model has two or more practitioners present in a session with the client simultaneously, as represented in Figure 2.8.

Figure 2.8: Interprofessional Joint Therapeutic Sessions Care Model



In the joint therapeutic care model, all (two or more) practitioners are present in consultations to create strong interactions between specialists and ensure complementary rather than contradictory advice is provided (O'Sullivan et al. 2018). In this model, clients openly interact with the practitioners and a team is formed that provides client-centered care, active listening, and a shared client narrative, all of which are key elements of interprofessional practice (Légaré et al. 2011). The joint sessions allow for parallel support from each practitioner and each health issue as needed and provide an opportunity for teamwork between both practitioners where they are able to reinforce and build on shared strengths.

In addition to the different interprofessional care approaches, several types of interprofessional intervention are identified that may be utilised alongside one of

the interprofessional care approaches on their own. These interventions may or may not include the client directly at the time of the intervention. For example, externally facilitated interprofessional interventions (e.g. training in interprofessional competencies provided by an external facilitator) (e.g. Zwarenstein and Bryant 2000), interprofessional rounds at the bedside (two or more practitioners from different professions performing a case presentation, physical exam, or discussion of a daily care plan with a client at their bedside in a hospital) (e.g. Gonzalo et al. 2014), and interprofessional team meetings (two or more practitioners from different professions meeting to discuss case presentations, daily care plans, or client needs. May or may not include the client in the team meeting) (e.g. Nisbet, Dunn and Lincoln 2015; van Dongen et al. 2017). The development of models and interprofessional practice approaches has helped researchers tease out the interprofessional teamwork mechanisms discussed in the next section.

2.1.5 Mechanisms of interprofessional teamwork to define practice

Understanding what interprofessional practice '*is*' is not complete without knowing '*how to do it'*. Practitioners, organisations, and policymakers need to understand how to turn the concept of interprofessional practice into a reality by using the best available evidence to inform current practice. However, to interpret how mechanisms of interprofessional teamwork define practice, we first need to understand teamwork in general. In a study of collaboration mechanisms, Salas, Sims and Burke (2005) identified that teams do more than interact with tools. Teams require the ability to communicate with each other in a collaborative process to facilitate task intentions. A shared understanding of team resources,

goals and objectives is required, as well as knowledge of the constraints under which the team works. This investigation led Salas et al. (2005) to propose the *'Big Five'* mechanisms of teamwork. They suggested a focal set of teamwork components would be required to complete any task. These components are shown in Table 2.2 with their original definitions.

Table 2.2 Big Five mechanisms of teamwork (adapted from Salas et al. 2005)

Teamwork mechanism	Definition
Team leadership	To guide and structure team experiences to facilitate coordination and adaptive action (Stewart and Manz 1995)
Mutual performance monitoring	Monitoring team members' work as well as their own and ensure that the whole team are following procedures correctly (McIntyre and Salas 1995)
Backup behaviour	Negotiating resources and task-related effort to other members of the team when required (Porter, Bigley and Steers 2003)
Adaptability	The ability to recognise deviations from expected action and re-adjust actions accordingly (Burke et al. 2003)
Team orientation	Working with others and enhancing individual performance through the coordination, evaluation, and utilisation of task inputs from other members (Driskell and Salas 1992)

In addition to these five core mechanisms of teamwork, Salas et al. (2005) proposed three components; shared mental models, closed-looped communication (a three-step process, where 1) the transmitter communicates a message to the intended receiver, utilizing their name when possible, 2) the receiver accepts the message with acknowledgment of receipt via verbal confirmation, seeking clarification if required and 3) the original transmitter verifies that the message has been received and correctly interpreted, thereby closing the loop (Burke et al. 2004), and mutual trust. These are behaviours need to be present within a team to enable teamwork. Salas et al. (2005) noted that these three coordinating components allowed team flexibility in allocating and completing tasks. The *'Big Five'* mechanisms are requirements for team effectiveness, but Salas et al. noted that the challenges faced by individual teams would require applications of each of the components in different ways. The proposal by Salas et al. for a contingent application of the *'Big Five'* teamwork mechanisms aligns with the proposition of a contingent approach to defining interprofessional practice by Reeves et al. (2018). Identifying the team mechanisms of interprofessional practice could provide an opportunity to compare these mechanisms with those of the '*Big Five'* mechanisms for general teamwork. This comparison would illuminate unique characteristics of interprofessional practice, which may enhance our understanding of the properties of this form of teamwork compared to usual teamwork.

The National Institute for Health Research in the United Kingdom published a study in 2013 on interprofessional practice across stroke care pathways (Harris et al. 2013). In this study, Harris et al. identified 13 mechanisms that underpin interprofessional teamwork, as shown in Table 2.3. These mechanisms formed an

analytical framework used throughout the study to explore teamwork from the perspective of clients, carers and stroke service staff (Harris et al. 2013; Hewitt et al. 2014, 2015*; Sims et al. 2015a, 2015b).

Table 2.3 An analytical framework of interprofessional teamwork mechanisms. (Harris et al. 2013).

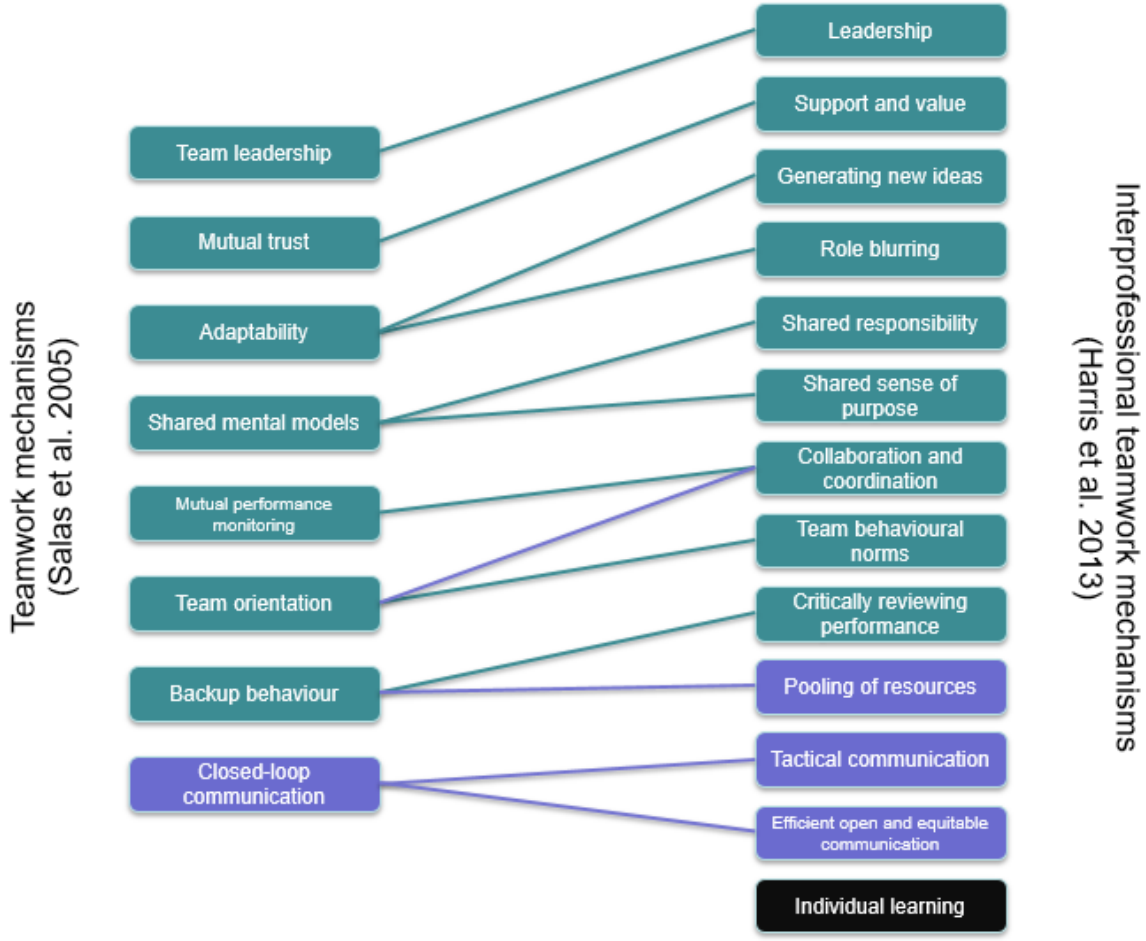
Teamwork mechanism	Description
A shared sense of purpose	An explicit and shared understanding of objectives, consistent approach, enhancing motivation and commitment
Pooling of resources	The ability to pool diverse knowledge, skills, experience, influence, resources and networks
Collaboration and coordination	Allows members to collaborate and coordinate their work, reducing duplication and protects from gaps in processes
Efficient, open and equitable communication	Open communication allowing members to offer opinion and challenge others with due consideration
Shared responsibility and influence	Team members influence decisions and share responsibility for them

Support and value	Team members feel supported and valued and have mutual trust and respect for each other
Critically reviewing performance and decisions	Group reflection and critical review of performance and decisions
Generating and implementing new ideas	Opportunities for collective learning and development
Individual learning	Individual learning opportunities and relationships which promote professional development
Leadership	Establishment of the team culture, engagement, motivation and communication
Tactical communication	Control of the amount or type of information shared
Role blurring	Shared body of knowledge and skills between team members
Team behavioural norms	Development and sharing of behavioural rules

By comparing the interprofessional mechanisms from the Harris et al. (2013) study with the *'Big Five'* mechanisms of teamwork defined by Salas et al. (2005), we can

align the interprofessional mechanisms within those for general teamwork. The matrix in Figure 2.9 illustrates the alignment of these two sets of mechanisms, with an indicator of a close match (GREEN), loose match (PURPLE), and non-alignment (BLACK).

Figure 2.9 Alignment of mechanisms identified in interprofessional teams and those of general teamwork.



This figure compares the mechanisms from interprofessional teamwork (Harris et al. 2013) with those of general teamwork (Salas et al. 2005). The matrix illustrates the alignment of these two sets of mechanisms, with an indicator of a close match (GREEN), loose match (PURPLE), and non-alignment (BLACK).

There are six mechanisms of the *'Big Five'* that align closely with the mechanisms of interprofessional teams. These are team leadership, mutual performance monitoring, backup behaviour, adaptability, and team orientation, shared mental models, and mutual trust. Only one of the *'Big Five'* has a loose match to the interprofessional team mechanisms, closed-loop communication, a coordinating component of overall teamwork. This overall alignment demonstrates that six mechanisms of interprofessional teamwork are similar to general teamwork

The communication mechanisms found in interprofessional teamwork align loosely to the *'Big Five'* mechanism of closed-loop communication. This communication mechanism in the *'Big Five'* is somewhat transactional and does not allow for discussion between team members. This type of communication is expected in healthcare in handover type situations such as emergency care and ambulatory care, where specific information needs consistency in the way it is delivered to minimise error (Alert 2017). In contrast, the interprofessional teamwork mechanisms described by Harris et al. (2013), being efficient, open and equitable communication, and tactical communication, are more open and expressive forms of communication which are less about a transaction and more about the structure and intent of the interaction. Within interprofessional teamwork, it may be more important to focus on the intention of the communication, the language, and the communication tools, than in other forms of partnership. Communication competence is one of the critical mechanisms required to prevent adverse events in the healthcare system (Rosenstein and O'Daniel 2008). Therefore, it is not surprising that the interprofessional communication mechanisms identified by Harris et al. (2013) require greater communication competence than in other teamwork environments.

Another loosely aligned mechanism between overall teamwork models and interprofessional teams was the mechanism identified by Harris et al. (2013) as a pooling of resources, which aligns to some degree with the *'Big Five'* mechanism of backup behaviour. The pooling mechanism was closely linked to open communication and aspects of support and value in the Harris et al. (2013) model. Space and time to communicate, both formally and informally, were required to pool information and experiences. At the team level, pooling resources improved problem-solving and decision-making and helped teams arrive at mutually agreed decisions. Pooling also helped teams develop integrated treatment plans and supported role blurring between team members. However, the most frequently cited outcome was that pooling led to a more holistic understanding of the client, leading to optimal care (Harris et al. 2013).

Of the interprofessional mechanisms in the Harris et al. (2013) model, only one does not align with the *'Big Five'* core team components and their coordinating mechanisms. That mechanism is *'individual learning'*, identified in interprofessional teamwork by Harris et al. (2013) in studies that suggested gaining knowledge of each other and understanding client care was an essential part of working together efficiently. Individual learning has been acknowledged as so important for health practitioners to function effectively in interprofessional teams that is should be embedded across the lifespan of their career, from pre-qualifying education to continued professional development (Barr et al. 2016). The Centre for Advancement of Interprofessional Education defines this ongoing learning as,

"*The means by which members of two or more professions learn with, from and about each other to extend and reinforce collaborative competence to improve quality and safety in practice*" (CAIPE 2015, p 17).

Interprofessional practice incorporates the notion that each practitioner is responsible for their learning continuum (Barr et al. 2016). Harris et al. (2013) reported that individual learning occurred through open communication between team members and supportive leadership within the team. Understanding the properties of leadership within an interprofessional practice approach may help to unlock how these teams' function.

2.1.6 Interprofessional leadership guides' practice

Interprofessional practice has demanded a shift in the concept of healthcare leadership for all professions involved in team-based care in both acute and chronic care settings (e.g. Forman 2020; Schot, Tummers and Noordegraaf 2020; Varpio and Teunissen 2021). The challenge of enabling seamless work practices amongst teams of practitioners from different professions, who are skilled in different ways, does not fit traditional leadership models (Smith et al. 2018). The integration of mutual power and influence across teams is not straightforward and has been challenged for its contradiction to the fundamental tenets of professionalism (Reeves et al. 2010). Traditionally, professions were led by leaders in their fields (i.e. nurses by nurses, physicians by physicians), but in interprofessional teams, these profession-based divisions in leadership are not promoted. The team lead may be from one profession, or the leadership may be shared across multiple team members from different professions. However, it is

not always possible that the members leading the team at any point in time have significant professional expertise across all other professions in the team. This lack of professional credibility at the point of authority makes interprofessional leadership more demanding (Smith et al. 2018). Further, the interprofessional team lead needs to navigate the tugs of professional autonomy within the group to ensure they integrate their practices as a team. A single model of leadership for this scenario has not been developed, or indeed, is warranted (Forman et al. 2015).

Sadideen et al. (2015) state that key leadership attributes can be developed through observation, experience, and education. In studies that included both senior and junior members of different professions in interprofessional team scenarios, many leadership behaviours were seen to be shared across the team. Smith et al. (2018) reviewed papers specifically examining interprofessional leadership from which they generated themes that contributed to a framework for this leadership model. These researchers were then able to compare the interprofessional leadership themes with those of teamwork leadership more broadly. Several factors were found in common: achieving organisational goals, managing performance, managing external relationships, and demonstrating technical expertise (e.g. Burke et al. 2006; LaFasto and Larssen 2002; Stoker 2008). However, interprofessional leaders demonstrated unique skills in promoting transformation and change as part of their role (Smith et al. 2018). West et al. (2003) concur with this interprofessional leadership requirement, finding that team leaders need to predict innovation consistently.

Even though Smith et al. (2018) found innovation leadership unique to the interprofessional teams they were researching, the link between interprofessional team performance and innovation is not new. Most major corporations have research and development departments that comprise teams of diverse professions with diverse abilities (Shen et al 2009). Research on such teams has also focused on the role that team dynamics (Nyström 1979) and team conflict (De Dreu 2006) play in enhancing team innovation. The leadership styles within these interprofessional teams are most often seen as transformational (creating change), which requires innovation. However, the focus is on developing innovation to meet company and client needs, not changing the company to meet different needs. Further studies on interprofessional leadership are being called for with some urgency, with an absence of shared theories and conceptual models of effective leadership making it challenging to evaluate the outcomes of interprofessional leadership practices (Brewer et al. 2016).

2.1.7 The essence of being interprofessional

The previous sections have helped demonstrate how practitioners in interprofessional practice learn from each other, their mechanisms in practice, and how they relate to each other. Nevertheless, studies are starting to question whether these interprofessional mechanisms are enough to differentiate interprofessional practice from other forms of multi-practitioner healthcare teams (e.g. Flood 2017; Wei et al. 2020) as they do not provide an element that is unique and essential in or of themselves. Instead, they have turned their attention to seek what it means to be interprofessional.

Outside of mechanisms and measurable skills, the term '*being interprofessional'* conjures up a sense of qualities of human nature (Hammick et al. 2009). Just as clients bring different values and knowledge to each interaction, so too do their practitioners. Each practitioner has their unique perspective, which comes from their journey in life and their understanding of their profession. These differences are valued as they contribute to successful interprofessional teamwork outcomes (Hammick et al. 2009). To work together in interprofessional teams, practitioners need to have a disposition that facilitates the development of reciprocal, mutually respectful relationships. Hammick et al. (2009) note that being interprofessional involves respect, confidence, willingness, and an approachable attitude, while Besner (2008) emphasises the importance of interprofessional practitioners working together rather than in opposition of each other, either knowingly or unknowingly.

Being interprofessional implies a unique way of working and a particular way of taking part in team activities (D'Amour and Oandason 2005). The thinking, feeling, and doing of interprofessional practice come together to make this form of practice different from usual care (Hammick et al. 2009). However, being interprofessional cannot be achieved in isolation from other practitioners, or other professions. Flood (2017) illuminated the complex nature of effective interprofessional practice which requires both interrelatedness and interdependence between practitioners. Her study utilised a hermeneutic phenomenological approach to examining the experience of 12 health professionals from nursing, occupational therapy, physiotherapy, speech and language therapy, medicine, social work, and midwifery. This research followed the practitioner's individual experiences of being part of a health setting that

utilised an interprofessional practice approach to care. Flood (2017) illustrated three emerging themes: a calling to be part of an interprofessional team, the spirit of taking part in interprofessional teamwork, and the safeguarding and preserving aspects of being in the team. Flood noted that all three of these themes were positive aspects of being interprofessional. However, it is essential to note that her study did not seek to illuminate themes that may have restricted practitioners, such as creating blocks, retreating behaviours or even feelings of failure within team practice. While these barriers to being interprofessional have not been investigated from a sensemaking perspective, the overall experience of being in an interprofessional team points to a spirit, or essence, within the team. This spirit comes from the participants and develops within the team by the way the practitioners act and what they bring into the experience (Flood 2017).

In their study Wei et al. (2020) sought practitioner's perspectives on ways to promote interprofessional practice with colleagues who may not be familiar with this approach. The report of Wei et al. (2020) concurs with Flood (2017), highlighting that the culture of caring that interprofessional team members bring to the team helps create human connections. Together these two studies suggest that the essence of interprofessional practice may reside in the individual commitment and collaborative effort that practitioners bring to the team when they engage in team-based care of clients. Further research is warranted to explore the development of this spirit of being interprofessional, with a view to harnessing this essence to expand interprofessional practice across additional healthcare domains.

2.1.8 What we know, and do not know, about being interprofessional

In summary, an interprofessional practice approach is one type of team-based healthcare practice. This approach is based on interprofessional values and the development of multiple teamwork competencies. Some studies have demonstrated that interprofessional practice has unique properties that differentiate it from other teamwork types. For example, the comparisons between interprofessional teams and general teamwork described in this chapter demonstrate a distinct set of factors that an interprofessional practice approach brings to the healthcare teams. However, studies have not explicitly focused on assessing what interprofessional practice is not, which may help properly differentiate interprofessional practice from other team-based models. Nevertheless, one of the most striking aspects of interprofessional practice that has been reported is the spirit of being called to be together, to act together and respect each other that clearly shines through in the story's practitioners recollect of being interprofessional (Flood et al. 2019; Wei et al. 2020).

While understanding these factors is essential, researchers have called for critical analysis of why collaboration is more effective in some settings compared to others. An analysis of this type needs to explore how interprofessional teams utilise teamwork mechanisms in specific care settings and how the nature of spirit impacts being interprofessional.

2.2 How practitioners provide client-centered care

Practitioners working in an interprofessional team base this care on the principle of being client-centered (Cohn and Cason 2019; Nicaise et al. 2021; Yun and Choi

2019). However, the definition of being client-centered in healthcare has been debated in the literature for many decades. Patterson (1990) wrote a paper entitled *'On being client-centered'*, that summated 50 years of client-centered theory and practice. In this paper, Patterson refuted the many attempts to soften or broaden the definition of client-centered practice in psychology which, at the time, was introducing concepts such as dream analysis, hypnosis, and guided fantasies as client-centered techniques (Patterson 1990). He reinstated the three essential elements of client-centered therapy that make this concept unique. First, client-centered therapy is a practice of empathic understanding where a power is not used to influence the client. Second, practitioners must respect and trust the client to control the rate of the therapeutic process. Third, the practitioner's trust in the client must be complete. Patterson was adamant client-centered therapy was an approach that stood alone and could not be incorporated into any other techniques.

More recently, Rowe (2011) reported that the basis for client-centered care could be derived from sociological rather than psychological theories. These theories included functionalism (each aspect of society works for the stability of the whole), conflict theory (perpetual conflict is created in society due to competition for limited resources) and social constructionism (a jointly constructed worldview that forms the basis for shared assumptions about reality). However, Rowe's overall theory did not progress to a published definition of client-centered care. Hudon et al. (2012) did attempt to derive a definition of client-centered care. Based on a systematic review of client-centered care in chronic disease management, Hudon et al. (2012) identified six major themes shown in Table 2.4.

Table 2.4 Themes identified in client-centered care as part of chronic disease management. (Adapted from Hudon et al. 2012)

Theme	Description
Starting from the client's situation	Developing a rich knowledge of the client's background and unique experience of illness
Legitimising the illness experience	Naming the illness or addressing the uncertainty of the diagnosis. Acknowledging the client's struggles
Acknowledging the client's expertise in his/her own life	Believe in the client's capacity to self-manage
Developing an ongoing partnership	Creating a sustained and coordinated plan between the practitioner and client
Offering realistic hope	Opening offering options for the future
Providing advocacy for the client in the healthcare system	Guiding the client through the healthcare system

Hudon et al. (2012) noted that client-centered care in chronic disease management called for ongoing adaptations by the practitioner to meet the fluctuating needs of the client. Mulley, Trimble and Elwyn (2012) concurred with the themes developed by Hudon et al. in their paper on silent misdiagnosis and client preferences. Mulley et al. summated these themes as respectful and responsive to individual client preferences, needs and values. Being client-

centered is now considered a core element of high-quality healthcare (Sunderji et al. 2017) and is generally related to a higher quality of life, with lower anxiety and depression (Parker 2019; Yamamoto 2020).

2.2.1 What is shared decision-making

Like client-centered care, shared decision-making has its origins in the development of the biopsychosocial model of healthcare (Cleak 2019; Yun and Choi 2019). An exploration of the development of this new model is important to understanding the shift that took place from the traditional, biomedical model of care, to including clients in shared decision-making.

In the 1950s, driven from an ethical standpoint, a paradigm shift saw a move from a biomedical model of healthcare to a more client-focused model (Balint 1957). Before this shift, the traditional model of healthcare focused on disease and the physician's ability to diagnose and treat known diseases. In this traditional model clients were well versed in the knowledge of physicians and trusted them to diagnose and prescribe treatment based on the best experience of the day.

Balint (1957), together with Engel (1960), adopted a psychosocial perspective to challenge this traditional perspective with an ethical view that the client's perception of illness might not always align with the physician's disease concept. They explained in the two concepts that a disease is a diagnosis of a deviation from wellness, whereas illness is a perception that the client does not feel well. The two meanings are not mutually exclusive or mutually inclusive. A client can feel unwell without being diagnosed with a disease. In contrast, a diagnosis for a

client with a disease can be made without the client feeling unwell (Jennings 1986).

Engel challenged the biomedical model with this paradox of disease vs illness in a series of papers (1960, 1977a, 1977b, 1978). This challenge culminated in his biopsychosocial model (Engel 1980), a model which would broaden the biomedical model without sacrificing any of its elements. Engel's new model included psychological and social information about the client in deciding forms of treatment. The inclusion of data from both the physician's biomedical perspective of the client's requirements and the psychosocial perspective of the client's concerns is the fundamental basis for shared decision-making, sharing the two contexts in deciding the right treatment for the client. Holding both perspectives in balance during decision-making is a critical element in client-centered care, and the basis for the well-utilised phrase *'having the client in the centre of care delivery'* (Orchard and Bainbridge 2015; McCance, McCormack and Dewing 2011).

Engel's biopsychosocial model is not without criticism. Many found the model vague and not verified scientifically (Foss and Rothenberg 1987; Malmgren 2005; van Oudenhove and Cuypers 2014). Others found the scope of the biopsychosocial model to be too generic and not ready to be put into practice effectively (Freudenreich, Kontos and Querques 2010; Ghaemi 2010; Schwartz and Wiggins 1985). Researchers, such as Herman (2005) argued that the psychological and social information relevant to the client was unwieldy to collect and thus too time-consuming to incorporate into medical treatment processes. Further to this dilemma was how to identify the relevant psychological and social

data required for a shared-decision. Researchers of the time proposed other models that tried to compensate for the criticisms of the biopsychosocial model. For example, Schwartz and Wiggins (1985) proposed the phenomenological model that focused on understanding the client's needs yet could not overcome the problem of containing the information gathered in a suitable time for the physician's needs. Foss and Rothenberg (1987) countered with the info-medical model, which was more comprehensive in the range of information collected and recorded. However, this model was not based on biomedicine but the biochemistry of the psycho-neuro-immunological system. This system was complicated and posed its own set of limitations, so it was not widely adopted.

More recently, Smith et al. (2013) proposed a solution that aims to overcome the limitations of the biopsychosocial model. Their shared decision-making methodology integrates client-centered and physician-centered interview models into a 12-step interview process. This twelve-step process is provided in Table xx.

Table 2.5: Integrated client-centered and practitioner-centered interview model. Adapted from Smith et al. (2013)

Step	Phase of interview
Client-centered interviewing method (5-steps, 21-substeps)	
1	Setting the Stage for the interview (i) Welcome the client (ii) Use the client's name (iii) Introduce self and identify specific role (iv) Ensure client readiness and privacy (v) Remove barriers to communication (vi) Ensure comfort and put the client at ease
2	Chief Concern/Agenda setting (i) Indicate time available (ii) Indicate own needs

	(iii) Obtain list of all issue's client wants to discuss; e.g. specific symptoms, requests, expectations, understanding (iv) Summarise and finalise the agenda; negotiate specifics if too many agenda items
3	Opening the History of Present Illness (HPI) (i) Open-ended beginning question focused on Chief Concern (ii) 'Nonfocusing' open-ended skills (Attentive Listening): silence, neutral utterances, nonverbal encouragement (iii) Obtain additional data from nonverbal sources: nonverbal cues, physical characteristics, autonomic changes, accoutrements, and environment
4	Continuing the Client-Centered History of Present Illness (HPI) (i) Physical component of story – obtain description of the physical symptoms [focusing on open-ended skills] (ii) Personal and social component of story – develop the more general personal/social context of the physical symptoms [focusing on open-ended skills] (iii) Emotional component of story – develop an emotional focus [emotion-sekking skills] (iv) Empathic responses – address the emotion(s) [emotion-handling skills: name, understand, respect, support] (v) Expand story and responses – expand the story to new chapters (focused open-ended skills, emotion-sekking skills, emotion-handling skills)
5	Transition to the Physician-Centered History of Present Illness (HPI) (i) Brief summary (ii) Check accuracy (iii) Indicate that both content and style of inquiry will change if the client is ready
Practitioner-centered interviewing method (7 steps)	
6	Overview and Summary of History of Present Illness (HPI)
7	Completing the History of Present Illness (HPI) Primarily using closed-ended, directive interviewing
8	Other health issues, e.g. diet, functional status, health hazards, sexual preferences
9	Past medical history, e.g. medications, prior hospitalisations and surgery, allergies

10	Social history, e.g. current living situation, early development, marital history
11	Family history, e.g. family genogram, diseases in family
12	Review of symptoms, e.g. review for any symptoms not previously given by the client

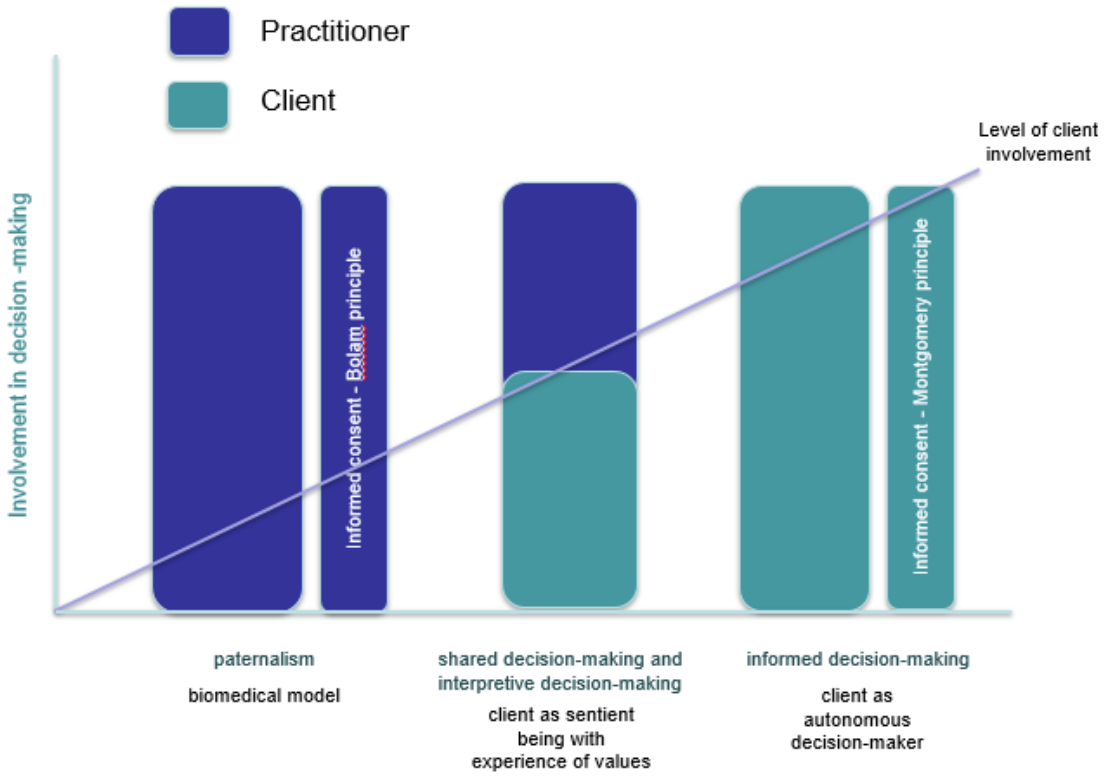
Smith et al. (2013) argue that providing a repeatable method consistent in identifying the elements needed for shared decision-making at each visit would offer a scientific model that could be useful for clinical, educational and research purposes. The premise for this model is a balance between rigour in application with humanistic needs of individual clients. To date, the 12-step process proposed by Smith et al. (2013) has not been widely utilised in research or clinical settings. One of the problems hindering the uptake of a standardised decision-making template is identifying a single shared decision-making process. These different types of processes of shared decision-making are explored in the next section.

2.2.2 Models of decision-making in healthcare

Shared decision-making is promoted as a critical element of client-centered care globally, that is, as a way to tailor evidence-based guidelines to individual client needs (Athwal et al. 2014; Légaré et al. 2011; Stacey et al. 2008). One of the problems hindering the uptake of client-centered care is that there is no single model of how clients interact with health professionals in decision-making that can be applied across all care settings. Four models of decision-making are prevalent in the literature: paternalism, shared decision-making and interpretative decision-making (often group together due to their combined focus on the practitioner and

client involvement in decision-making), and informed decision-making, as shown in Figure 2.10 (adapted from Wirtz, Cribb and Barber 2006).

Figure 2.10 Models of decision-making (adapted from Wirtz, Cribb and Barber 2006)



Each model has an element of shared decision-making. They all involve considering information from both the practitioner (therapeutic) and client (values-based) in developing a treatment plan that the client both accepts and utilises. However, the models differ in the amount of input the client has in the decision-making and the mode of accountability the practitioner has in providing information. A discussion of each model follows.

Paternalism

Paternalism is a form of decision-making that relies on the biomedical model in which the practitioner determines the action for the client based on their expert knowledge of disease (Emanuel and Emanuel 1992; Adams and Drake 2006). In this model, the client is not involved with the decision because they are recognised to have limited health knowledge and thus not qualified to determine a course of health management. Consequently, the client's role in this model is to trust and comply with their practitioner's decision (Laine and Davidoff 1996; Sagoff 2013). The trust component is twofold; the client must believe that the practitioner is suitably trained in disease management and is acting in the client's best interest. With this trust in place, identifying the client's preferences is not necessary as the practitioner decides what they feel is best for the client (Sagoff 2013).

Informed consent under this model is governed by the Bolam principle (Main and Adair 2015), which determines how much information is necessarily shared with the client to avoid liability in negligence for any adverse events. This principle states that a practitioner (typically a physician) must act in accordance with an accepted practice as proper by a person skilled in the art of medicine. Therefore, a physician would rely on their professional judgment to determine the amount of information to share or disclose with the client. This model is often criticised, as the physician's information may be shaped to be readily accepted and agreed upon by the client (e.g. Emanuel and Emanuel 1992; Fix et al. 2018; Huynh and Dicke-Bohmann 2020).

Interpretative decision-making and shared decision-making

Interpretative and shared decision-making include the client voice in determining the treatment of care. These models bring together information from the practitioner's medical knowledge and the values, beliefs, and social considerations of the client in the decision-making process (Gibson 2019; Puchalski et al. 2006; Roberts and Sarangi 2005). The layer of involvement of the client provides the difference between the models. In the interpretative model (Emanuel and Emanuel 1992), the practitioner combines the two states of knowledge and prepares a treatment plan on behalf of the client that fits best with their understanding of the combined needs. On the other hand, shared decision-making requires that at least two participants are part of the decision, the practitioner and the client. Together they share their knowledge and jointly develop a plan of care (Charles et al. 1997; Frosch et al. 2012; Stacey et al. 2008).

Informed decision-making

In the informed decision-making model, the client decides on a treatment plan's elements or direction after the practitioner discloses benefits, risks, and alternative treatment options. The practitioner remains impartial in the process and often provides written material as well as suggestions for second opinions. However, challenges were raised to using the informed decision-making model, which led to a change in the principle of informed consent. A legal challenge to the Bolam principle in the United Kingdom Supreme Court, known as the Montgomery case (Adshead et al. 2018; Chan et al. 2017; Smith 2017), provided an alternative regulation to informed consent based on the Bolam principle. This new statement

proclaimed that practitioners are obliged to ensure that clients have all the information they require before the client decides on their form of treatment. This change to the principle of informed consent moved the emphasis on knowledge and decision-making from the physician to the client (Sturgess, Clapp and Fleisher 2019). The Montgomery case raised the attention of the medical profession to a heightened risk of legal action based on practitioners not having enough up-to-date information about issues or items clients may require meeting their health needs (Lee 2017). Additionally, clients are becoming better informed, but not always from the most reliable sources, for example clients are drawing from information from online health sites which are not backed by medical science (Adane et al. 2020; Coiera 1996; Murphy 2018) which adds a burden on practitioners to counter some of this misinformation.

The four decision-making models should be viewed as a spectrum of client involvement rather than discrete models (Charles et al. 1999). Each practitioner and client dyad has an individual focus that may require combining these models in a single decision. For example, a client may prefer a physician to prescribe medications in a more biomedical approach but will prefer ongoing consultation and an informed approach to shared decision-making for lifestyle changes such as diet and exercise. Finally, it needs to be noted that many clients choose to follow the advice of their practitioners in regards to all aspects of their healthcare in what would seem to be a paternalistic model (Blease and Trachsel 2016; Cassileth et al. 1980; Degner et al., 1997; Muaygil 2018). As the client chooses to follow the paternalistic model, this trust in the practitioner's decision on their behalf is a form of shared decision-making and client-centered care.

Within the context of chronic healthcare, decision-making, whether using a biomedical or informed decision-making model for the treatment decision, almost always involves the client in the responsibility for the outcome. The client may, or may not, be included in decision-making about their care with the practitioner, but once at home, the client becomes responsible for their daily actions, including following through with the treatment plan (Tol et al. 2015; McColl-Kennedy et al. 2017). Learning to manage a chronic condition requires the client to take on new knowledge and responsibility (Falvo and Holland 2017; Jaarsma et al. 2017). Contemporary decision-making models for chronic conditions have the practitioner as a guide, helping the client make informed daily choices about living with their condition. These daily choices lead to accomplishing client goals through self-management and focusing on the client's quality of life (Audulv et al. 2019). Therefore, enhancing the client's participation in shared decision-making is based on the client's engagement with the healthcare process (McCorkle et al. 2011).

2.2.3 Client engagement in shared decision-making

Dixon, Holoshitz and Nossell (2016) provided evidence that people living with complex chronic conditions adhere better to treatment if shared decision-making is included in developing a treatment plan. In essence, by applying shared decision-making and actively involving the client in the decision through elicitation of their preferences and values, barriers to clients following through on decisions, and subsequently, the quality of care may be increased (Boss et al. 2016). Based on this type of evidence, the National Institute for Health and Care Excellence in the United Kingdom (NIH 2017) and the Institute of Medicine in the United States (IoM 2017) have acknowledged the need to address the psychosocial dimensions of

clients' health concerns and have issued imperatives to improve client-centered practices.

Providing imperatives on the inclusion of clients in healthcare is contrary to the way people engage in other areas of life where engagement is expected without such direction. However, Hodgkin and Taylor (2013) suggest that these imperatives are needed to steer healthcare in the direction of client engagement and responsibility. Paternalistic models of care that emphasise the practitioner's responsibility for treatment outcomes are inherently disempowering for the client with behaviours and practices of clients dependent and passive with this care model (Hodgkin and Taylor 2013). The shift to biopsychosocial models of care demands the engagement of clients, which is providing uncertainty on the increasing responsibilities clients have regarding their interactions with health providers.

To be able to engage with healthcare providers, clients require knowledge, skill and confidence to manage their health (Hibbard and Mahoney 2010). Client engagement is a broad concept that includes client activation (confidence and skills), health literacy (knowledge of navigating the health system) and client preparedness (being ready for the process of shared decision-making) (Novak et al. 2013). Not having competence in any one of these areas becomes a barrier to client engagement (Coulter 2012). Understanding a client's level of preparedness and capabilities to self-manage helps healthcare providers target client education, support individual client's needs, and effectively support self-management (Hibbard et al. 2005).

Joseph-Williams, Elwyn and Edwards (2014) reported that some clients feel that the limited time allocated for consultations is insufficient for shared decision-making. Studies by Fraenkel, Johnson and Polak (2019) have added that these time limitations stifle the client's ability to become informed, have time to process or reflect on the information they have received, ask questions, or raise concerns and discuss issues with clinicians. Adequate time for discussion has been shown to facilitate shared decision-making (Bastiaens et al. 2007; O'Brien et al. 2013; Yahanda and Mozersky 2020) and afford opportunities for client-practitioner relationship building, which is essential for effective communication (Peek et al. 2010). Clients frequently report that clinicians seemed too busy and hurried so they do not want to bother them in treatment sessions (Joseph-Williams 2015). Other studies have also found that clients are sensitive to the high workload of health practitioners, feel guilty about taking up the clinicians' time (Frosch et al. 2012), pity clinicians because they seem so busy (Aasen, Kyangarsnes and Heggen 2012), and terminate consultations more quickly when waiting rooms are full (Bastiaens et al. 2007; Claramita et al. 2011).

Two analytical themes have been proposed that shape client participation in shared decision-making (Lloyd et al. 2013). The first theme relates to how the healthcare system is organised, that is, factors that are primarily outside of the clients' and practitioners' control. These factors include time, continuity of care, workflow and the healthcare setting. Some clients believe their right to participate in shared decision-making depends on whether they pay for their healthcare or not (Fraenkel and McGraw 2007). Overspecialisation of doctors, and lack of reimbursement for clinicians undertaking shared decision-making, have also been reported as barriers to shared decision-making (Belcher et al. 2006).

The second analytical theme proposed by Lloyd et al. (2013) relates to what happens during a decision-making interaction. Elements in this theme include the influence of the participants taking part in decision-making, predisposing factors, interactional influences, and preparation for the shared decision-making encounter (Lloyd et al. 2013). Joseph-Williams et al. (2014) also found that various client characteristics either facilitate or hinder client involvement in shared decision-making. Some of these characteristics are not modifiable within the treatment session, such as poor health (Bastiaens et al. 2007) and cognitive impairments such as dementia (Caress et al. 2002). Most client characteristics are, however, potentially modifiable, in terms of their influence on client engagement. Table 2.5 provides a composite list of reported modifiable barriers for client engagement.

Table 2.6 Barriers to client engagement open for modification

Client characteristic	Reference
Older age group (60+)	Adler, McGraw and McKinlay 1998
Younger age group (less than 12)	van Staa and On Your Own Feet Research Group 2011
Ethnic background (e.g. communication barriers)	Peek et al. 2010
Poor articulation (e.g. communication barriers)	Avis 1994; Caress et al. 2002
A lower level of education (did not complete high school)	Ågård, Hermerén and Herlitz 2004

Differences in personal characteristics between the client and the clinician (e.g. dialect, accent, age, sex)	Anoosheh et al. 2009
Nature of the health condition (e.g. infectious disease, drug addiction, alcoholism)	Thompson 2007
Long-term (chronic) condition (e.g. chronic pain)	Caress et al. 2002; Caress et al. 2005
Physical impairments (e.g. hearing)	Bastiaens et al. 2007

Whilst age and ethnicity are not directly modifiable, the barriers reported concerning these factors are linked to attitudes or prejudices shaped by practitioner training. For example, Bastiaens et al. (2007) demonstrated that some older clients (60+) believe they have been socialised to accept the authority of practitioners, which should not be questioned. Van Staa and the 'On Your Feet' research group (2011) also found that some young clients (less than 12) believe that parents will adopt the decision-making role. This parental role is often found in a triadic consultation (practitioner, client, parent) where young clients feel incapable of representing themselves. A cultural difference can also lead to this power imbalance. Peek et al. (2010) reported that African American men describe a power imbalance in the client-practitioner dyad is exacerbated by ethnic difference. They suggest this cultural difference can account for clients who may defer to authority or do not seek validation of their concerns.

The concept of preparedness to be part of one's own healthcare needs to be considered at the individual, organisational and community level. For an individual, being prepared to be part of their healthcare is more than just knowing that this is something they should do, or the ability to gain relevant knowledge when they need it (health literacy). To be prepared, they need to be socially, psychologically and physically able to participate in the treatment session and decisions that relate to their care plan. To differentiate clients that were ready to take part in care planning and those that were not, Ruesch and Brodsky (1968) coined the concept of *'social disability'*, to draw attention to a type of disability that was not self-evident to most people at the time. Normative standards had become diffused and the range of tolerable behaviour extended from the rigid and clearly defined notions of the previous decades. Ruesch and Brodsky (1968) argued for the first time that disability was no longer evident to everyone (physical disability) and could take many forms (for example, mental health or cultural differences). In more recent years, the terms '*diversity*' and *'cultural sensitivity'* have taken precedence over *'social disability'* to help recognise the culturally diverse populations and health disparities commonplace in most societies (Tucker et al. 2011). Cultural sensitivity has also become the term that recognises that both practitioners and staff of a healthcare service need to understand how to practice in a manner that is inclusive of all clients to improve healthcare delivery to culturally diverse populations. The challenges of meeting clients' cultural and social needs from all backgrounds and with many different types of needs when they engage in health services have required a new focus on enhancing client engagement strategies.

2.2.4 Client engagement strategies

Client engagement is determined by the relationship clients have with healthcare services as well as individual healthcare providers (Petriwskyj, Gibson and Webby 2014). To engage in an active two-way dialogue with their clients, healthcare practitioners need information from clients, such as information about their levels of health literacy and preconceptions of healthcare services. With this type of information, practitioners can help guide clients in a way that can allow them to be more engaged. Clients need to be supported to be able to participate in the communication that elicits this data. Client engagement strategies can take the form of either preparatory strategies (strategies that set the stage for a positive engagement at the beginning of treatment) or continuous strategies (strategies that build on client engagement as treatment progresses). Some preparatory procedures are used to improve treatment accessibility and communicate the nature of services and related expectations to potential clients, such as language support services (Nock and Ferriter 2005). Continuous strategies include goal setting, reinforcement, and progress monitoring. These strategies aim to facilitate collaborative decision-making and encourage the client's treatment efforts (Lewis et al. 2019; Nock and Ferriter 2005; Savic et al. 2017). Therefore, the use of these strategies throughout the client's association with the health service can help with treatment effectiveness. For interprofessional practice teams, the need to prepare and support clients in healthcare is often more difficult due to the multiple practitioners that may take part in the care program and complexity of the care plan. Therefore, shared decision-making for clients in an interprofessional team often requires additional planning.

2.2.5 Shared decision-making in interprofessional practice

The process of shared decision-making is central to an interprofessional approach. A review of the literature on conceptual frameworks for interprofessional practice by D'Amour et al. (2005) determined that sharing was one of the distinctive elements describing this collaborative approach to healthcare. Shared decision-making, one of the critical aspects of sharing, enables care providers to synergistically influence the client's care (Way et al. 2001). The information shared in this process comes from all team members and the client themselves, and as such, the shared decision-making process is a collaborative effort with the client. However, most studies have explored the concept of shared decision-making from the perspective of physicians and clients (LeBlanc et al. 2009; Légaré et al. 2008; Melbourne et al. 2010), or physicians and nurse dyads (Baldwin, Dimunation and Alexander 2011; Berger-Höger et al. 2015; Ganz et al. 2016). Very little is known about how shared decision-making occurs in a team comprised of practitioners from multiple professions (Dunn et al. 2013).

In an attempt to define client-centeredness from the client perspective, and using the client's voice, the phenomenological study of Greenfield et al. (2014) identified six themes representing core '*ingredients*' of client-centeredness in the interprofessional care context. The six themes identified by Greenfield et al. (2014) depicted client expectations and assumptions on practitioner and client roles in integrated care. These six themes are described in Table 2.6.

Table 2.7 Themes of client-centeredness in interprofessional practice (adapted from Greenfield et al. 2014)

Theme	Example
Holism	To be treated as a whole person. To be '*seen*' as an entire person with a complete life, not just medical symptoms, and having psychological as well as medical needs
Naming	To be uniquely acknowledged and respected
Heed	To be listened to and have proper attention, clinically (clinical judgment), and personally (telling their unique story)
Compassion	To be shown authentic empathy and warmth. The relationship with physicians is expected to extend from scientific medical care to a more personal, less formal relationship
Agency and empowerment	To be involved in care in an active and informed way
Continuity of care	To have a team that maintains continuity of care. This continuity is essential for establishing trusted relationships with regular practitioners, but also for being treated by a practitioner who knows their medical history and hence can see a coherent clinical picture

The themes identified by Greenfield et al. (2014) in relation to client-centered care in interprofessional practice are similar to the themes identified by Hudon et al.

(2012), shown in Table 2.4, which depicted client-centered care in a direct relationship with a single practitioner. The client's needs in an interprofessional practice approach are deepened by the team environment with a call for the client to be seen and heard by all team members. Greenfield et al. (2014) also noted that the client needs include continuity of team members in attending to their needs to maintain trusted relationships with practitioners who see a coherent picture of the client's needs.

The complexity of client-centered care and shared decision-making has raised issues in dualism (the application of one strategy creating the potential for two different responses), in the outcomes of applying strategies to meet the needs of clients in interprofessional care settings. The next section looks at these dualisms as they have been reported in the form of paradoxes in interprofessional care settings.

2.2.6 The potential paradox of interprofessional practice

Interprofessional practice offers opportunities for practitioners to work together and with their clients in meaningful ways. For example, the benefits of interprofessional practice include the notion of empowerment for both the practitioners and the clients, where practitioners are empowered to work together in a team structure that has defined roles and responsibilities and opportunities for leadership. In contrast, clients are empowered to be part of the structure of the teamwork by being the focus of the engagement (Adams 2008). Empirical studies have demonstrated that interprofessional practice leads to decreased professional paternalism, which is reported as a benefit for client engagement (D'Amour et al.

2005). Studies have also shown that clients appreciate specific expertise by different professional team members (Shaw 2008; Willumsen and Severinsson 2005).

However, recent studies have called attention to a paradox whereby interprofessional practice may add to the healthcare burden for practitioners and clients instead of easing them by introducing complexity with the perceptions of multiple professions to be considered for shared decision-making (Kvarnström et al. 2013). Interprofessional practice has also been questioned by Fox and Reeves (2015) for the ability of practitioner teamwork to shift the responsibility of adherence to treatment from the practitioner to the client following an informed decision-making model. Another area of concern raised by Fox and Reeves was the potential for medical dominance from physicians to be extended across other professions in the workings of an interprofessional team. Empowerment processes can be considered paternalistic, despite intentions to the contrary. For example, if the practitioners within a team, as experts in their field, decided on a plan for the client and then manoeuvred the client toward this goal. This paternalistic process may be steered by the team even when working within predetermined frameworks intended to prevent this paradox (Jones 2016; Veerapen 2017; Ziegler 2019).

Kvarnström et al. (2013) raised several other potential paradoxes of interprofessional practice in their study of clients in different types of interprofessional microsystems. First, they noted that teamwork could conceal an underlying structural imbalance of power between practitioners and clients. These researchers reported that some practitioners felt accountable for creating

participation opportunities (ensuring clients could participate in group social activities) for clients instead of supporting client engagement as a client responsibility. The imbalance in this responsibility for participation was also reported by Adams (2008) in understanding empowerment in social work in institutional settings.

Another paradox reported by Kvarnström et al. (2013) is the potential for unequal power relations noted by organisations who implied that both practitioners and clients were equal in their ability to attain resources for their respective goals. While at first pass, this view seems to imply shared accountability between practitioners and clients to attend sessions with the ability to participate in decision-making activities, it falls short in supporting vulnerable clients (e.g. those with communication barriers which may impede their understanding of their own accountability in the decision-making process). In particular, this view implies that it is the client's responsibility to avoid paternalism by taking an active role in treatment planning. The paradox with this view was also reported by Murdach (2008) in a study of negotiating with antisocial clients (e.g. clients whose behaviour indicates impaired insight into socially acceptable behaviour) in rehabilitation centres with clients ascribed physical and cognitive limitations. In both studies, the clients were more vulnerable to paternalism due to their reduced capacity to communicate. Together, these studies illuminated an imbalance of expectations, expertise, and liabilities potentially for misinterpretation by vulnerable clients in healthcare settings.

Another concern for an interprofessional practice approach can stem from an expectation that teamwork will support and nurture client engagement when, in

reality, the practical limitations of teamwork can lead to reduced or intermittent consultations with clients. In Kvarnström et al.'s (2013) study, over-promised and under-delivered consultations led to disempowering the client and calls of tokenism in team engagement. Kvarnström et al. alerted researchers to the possibility of the interprofessional team being deficient in supporting the client to participate to an acceptable level. Team member's need to be aware of their responsibility to engage in shared decision-making and that the development of the client's ability to engage in this process is the responsibility of all parties. Researchers have called for further studies into how practitioners can avoid these paradoxes in shared decision-making within interprofessional teamwork (Bunn et al. 2018; DiazGranados et al. 2018; Kvarnström et al. 2013; Pérez et al. 2018). Another important area of research to consider is how the client feels being part of an interprofessional team. The next section examines client feedback following involvement in an interprofessional care setting.

2.3 Client feedback of interprofessional practice in chronic care settings

The involvement of the individual client in the interprofessional team is multidimensional: they can be regarded both as a member of a team and as the recipient of its services (Thistlewaite 2008). Clients as well as welfare and health professionals in various service settings have expressed positive attitudes towards the principle of client participation (Lee and Charm 2002; Butow et al. 2007; Bryant et al. 2008). Nevertheless, clients' preferences for participation in areas such as decision-making are not uniform, ranging from passive to more active

roles and varying according to the individual's age and social status (Florin et al. 2006).

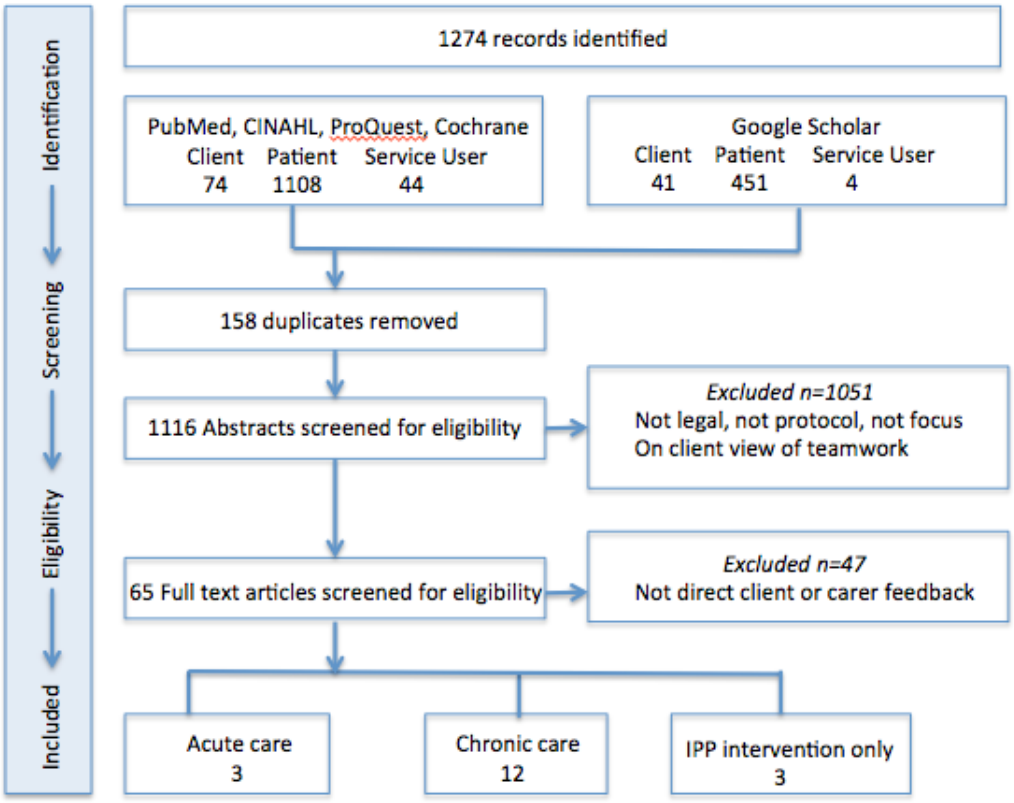
A systematic review following a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework (Grimmer-Somers, Atkinson, Dolejs, & Worley, 2008) was undertaken of the literature for studies which included client feedback during or following their experience as part of an interprofessional team in a chronic care setting. The inclusion and exclusion criteria for this systematic review is provided in Table 2.8. The search terms utilised were 'interprofessional' and 'client/patient/service user' in the title or abstract of the paper.

Table 2.8: Inclusion and exclusion criteria for systematic review of studies which included client feedback in an interprofessional practice care setting

Inclusion criteria	Exclusion criteria
1. A journal paper that investigated the feedback of clients or carers in interprofessional practice teams or team working in a chronic care setting. 2. Date range of 2000-2019	3. Interprofessional education studies 4. Interprofessional simulation studies 5. Inclusion of students 6. A book, or ebook 7. A non-peer reviewed article 8. A conference presentation 9. A model or framework description 10. Not available in English 11. Duplicate works using the same data source 12. Full text version not available

The literature search revealed 18 papers that published feedback from clients and/or their carers following an experience with interprofessional care in a health care setting. These papers were then categorized into those that only reported on an acute care setting (three papers), those that only reported on an interprofessional intervention without regard to the setting (three papers) and those that reported on longer term/chronic care (12 papers). The systematic review process flow is shown in Figure 2.11. Only studies which included client feedback following an experience of being part of an interprofessional practice team in a chronic care setting were included for further evaluation.

Figure 2.11: Literature eligibility search and selection flowchart



The studies identified by this systematic review and subsequently included in this review are listed in Table 2.8

Table 2.9: Articles included in review of client feedback in varying approaches to interprofessional practice in chronic care settings

Type of intervention	Title	Authors	No of clients/ carers	Type of client/carer feedback
Decision pathway	The care continuum with interprofessional oncology teams: Perspectives of patients and family	Bilodeau, Dubois, and Pepin (2015)	11	Observations and interview
Group care	An interprofessional approach to shared decision making: an exploratory case study with family caregivers of one IP home care team	Legare et al. (2014)	6	Interview
Group care	Are interprofessional healthcare teams meeting patient expectations? An exploration of the perceptions of patients and informal caregivers	Cutler, Morecroft, and Carey (2019)	14	Focus group
Group care	Interprofessional working in hospice day care and the patients' experience of the service	Lee (2002)	7	Interview, observations, document analysis
Collaborative care	Integrated primary care for patients with mental and physical multi-morbidity: cluster randomised controlled trial of collaborative car for patients with depression comorbid with diabetes or cardiovascular disease	Coventry et al. (2015)	350	Questionnaire
Collaborative care	How Service Users Perceive the Concept of Participation,	Kvarnstrom et al. (2012)	22	Interview

	Specifically in InterprofessionalPractice			
Therapeutic pathways	Interprofessional collaboration with service users in the development of cancer services: The Cancer Partnership Project	Sitzia, Cotterell, and Richardson (2006)	12	Interview
Therapeutic pathways	Interprofessional teamwork in stroke care: Is it visible or important to patients and carers?	Hewitt et al. (2015)	83	Critical incident interview
Joint therapeutic sessions	Comprehensive Clinical Adherence Interventions to Enable Antiretroviral Therapy: A Case Report	Nicca et al. (2007)	1	Interview, observations, document analysis
Joint therapeutic sessions	Open Trial of Integrated Primary Care Consultation for Medically Unexplained Symptoms	Hubley et al. (2016)	10	Questionnaire, interview
Joint therapeutic sessions	More than one dollop of cortex: patients' experiences of interprofessional care at an urban family health centre	Shaw (2018)	7	Interview
Joint therapeutic sessions	A qualitative exploration of the client experience of inter-professional practice in the delivery of ActivePlus: a combined smoking cessation and physical activity intervention	O'Sullivan et al. (2018)	7	Interview

Client satisfaction was only reported by Coventry et al. (2015) and Hustoft et al. (2018), and only when the clients were asked specifically as part of a questionnaire, suggesting that clients do not actively provide feedback on their own satisfaction with a service unless asked directly. Both studies that utilised the questionnaire approach for client feedback were very large studies with 350 clients contributing (Coventry et al. 2015) and 984 clients contributing (Hustoft et al.

2018) making the questionnaire approach the most economic and timely method of seeking client feedback.

A number of studies provided client feedback comparing the interprofessional approach to a traditional medical model. Across most of the different interprofessional approaches utilised clients provided feedback that they felt submissive and put trust in their General Practitioner above all other professions and felt some confusion, or were dismissive, in regards to the roles and responsibilities of other professions included in their care. This was often reported as a barrier to an interprofessional approach, however, as Coventry et al. (2015) reported,

> "*physicians, as the current constant in the client lives in this center, are in a prime position to explain the role of allied health*" (p. 8)

Therefore, the role of the physician should be used as a facilitator to an interprofessional approach helping clients understand the reason, roles and responsibilities of the whole team. The study of Hubley et al. (2016) reported clients who presented with medically unexplained symptoms. In this study they approached the use of an interprofessional model to support and compliment the usual primary care physician. A behavioural health provider met with the client over two consultation sessions to develop a client narrative, case conceptualization and treatment goals. These consultation sessions were then followed by a joint session with the primary care physician. In this team-based session the behavioural health provider helped the client to describe the content of the consultation sessions to the primary care physician. In this way the behaviour

health practitioner was facilitating a discussion between the client and their primary care physician to ensure there was a mutual understanding and that all of the client's questions were addressed. In this study clients remained in the program throughout its duration and reported favourably on the intervention providing encouragement for this type of approach. These two examples demonstrate that including a General Practitioner, as part of an interprofessional approach can be a facilitator to the client acceptance and benefits of a team-based approach.

Clients actively acknowledged team working, or awareness of practitioner teams, across all chronic care approaches with the exception of the collaborative care model. In this care approach the client communicates with a case manager on a regular basis and for longer sessions than they would normally spend in an individual practitioner session, and the case manager passes the information about the client gained from these sessions to the relevant practitioners who manage the clients ongoing care plan. The lack of client feedback in regard to awareness of the teamwork with the practitioners suggests that while the practitioners are interacting as an interprofessional team in this model, the client is not aware of the teamwork that is happening behind the scenes.

Clients frequently provided feedback that they were not participating in a team, or the teamwork was not visible to them, suggesting that although they understood that more than one practitioner was involved in their care they did not have any evidence that the practitioners were a team. This sentiment was most frequently reported where Group care or a Therapeutic pathways approach was utilised. The Group care and Therapeutic care approaches require a number of different

practitioners to be in contact with the client or carer, but the client is not aware that the practitioners are working together when they are not with the client. Clients in the study of Cutler et al. (2019) reported that from their experience that healthcare professionals introduced themselves as individuals and not as part of a team and Hewitt et al. (2015) as part of the stroke care pathway approach discussed how little participants talked about teamwork and provided a practical issue that would have compounded this experience such that,

> "*Carers had often not actually seen the teams and were, therefore, unable to comment on teamwork. Furthermore, a number of both clients and carers commented that they only saw professionals individually, particularly once home, and this limited their ability to talk about teamwork:* (Hewitt et al, 2015; p.337).

The element of whether the teamwork was visible or not to the client provides a valuable delineation between types of team working. If the teamwork is not visible to the client it could be considered to be a 'back of house' activity, happening behind the scenes in preparation or as an activity that supports the client care without being directly part of the client interaction. While teamwork that is visible to the client can be considered to be 'front of house' or an activity that is undertaken with, or for, the client in the presence of the client.

The theme of communication was widely reported across all studies with feedback recognised as both a facilitator and barrier to client care needs. Within the chronic care pathway approach the clients felt that there were listened to, respected, and

treated with kindness in a non-judgemental way within the research groups that included a joint therapeutic session approach in the interprofessional intervention.

The Group Care approach attracted the most feedback that including criticisms of the approach such as being a lack of continuity or formalised structure in communication, a lack of agreement in decisions that needed to be made, that computer based systems were ineffective and hindered communication, and that poor communication left the clients feeling abandoned, confused and stressful. This feedback suggests that a Group Care approach could be more harmful than helpful if the communication structure is not addressed appropriately.

The experience of Group Care in these studies is contradictory to several other research reports, such as that of Haslam et al. (2010) on Social Treatment, which proposed that,

> "*Group intervention is expected to heighten a shared sense of social identification among participants and encourage productive social engagement*" (p. 158)

Both factors have previously been shown to contribute to a range of positive health-related outcomes (Haslam et al. 2009; Tyler and Blader 2003). The reasons for the increased focus on communication with the research reported which utilised an interprofessional approach in Group Care may be because the clients in these studies have less time with the practitioners as they need to divide their time amongst a group rather than individual care, that the clients themselves may be feeling more isolated within the group care setting, and that the group care settings within the papers reviewed tended to be settings where the clients

remained over a longer term of care (home care, hospice day care) which may have added to the isolation and need for greater communication.

Client-centeredness is all about putting clients first, at the centre of health and social care, that is respectful and responsive to individual client preferences, needs and values (Mulley et al. 2012) and not surprisingly was a key theme amongst feedback from clients in chronic care with an interprofessional approach. The most frequent client feedback items within the chronic care settings came from clients that were part of a joint therapeutic session approach. This is not surprising as these clients spent the most time directly with two or more practitioners, and this setting provided the greatest number of papers published with direct client feedback. Overall, in this setting there were many more clients providing feedback that represented a facilitator to care than those that represented a barrier to care suggesting that the clients felt that the care provided was mostly respectful and responsive to their needs and preferences. Feedback that was considered to be a facilitator to care included that of client empowerment, listening and exploring with the client towards common goals, client owned decision making and that there was both a fluid and trusting relationship between the client and the practitioners participating in the joint therapeutic sessions.

The client experience of the joint therapeutic sessions was only represented by research that included joint therapeutic sessions which fell into the categories of collaborative care (where some joint therapeutic sessions were offered as well as the central care manager approach), therapeutic pathways (where joint therapeutic sessions were provided as an option as part of the pathway), and interprofessional interventions that had joint therapeutic sessions as their main

intervention. Reports of barriers and facilitators to care were spread evenly throughout this client feedback. The individual facilitators included that the joint therapeutic sessions were perceived to be beneficial, that the client adapted well to having multiple practitioners, and that the multiple practitioners provided both a new perspective for the client, and additional support for the practitioners involved. The reported barriers included general negative impressions of joint therapeutic sessions as well as concerns about client privacy and that the clients felt that having more than one practitioner would provide additional pressure on client adherence and potentially greater consequences of non-adherence. These studies were all early pilots or first-time interventions within their treatment settings and so it is not surprising that there would be some apprehension expressed by the clients as they participated in a setting for the first time. It is also noted that many of the studies did not provide reference to client preparation for the sessions in terms of their health literacy for navigating this new type of intervention, but this did not prohibit many of the clients becoming quite comfortable and appreciating the attention they received within a joint therapeutic session. Knowles et al. (2013) reported a practitioner noted,

> *"There was no awkwardness because by then [the final joint session] they knew her really well and they've known me for years and years .. I think it made it feel like it had come full circle, because it started off with me and it was finished off with me"* (p. 112)

This practitioner comment provided a view that the clients released anxiety and became more comfortable with the joint session approach with time and exposure

to multiple sessions. Kvarnström et al. (2012) also commented on the capacity of the client in a joint session scenario, noting that,

> "*such individual capacity includes communication ability or shyness as well as prior occupational experience of multiparty conversations*" (p. 140)

Once comfortable and prepared for a joint therapeutic session O'Sullivan et al. (2018) reported that client feedback was that they 'felt special' and 'the centre of attention'.

The analysis of individual feedback items provided in the research reports of clients from an interprofessional care setting, revealed a striking delineation in client feedback between clients who recognised or noted teamwork or team working with themselves and practitioners, and those that reported that the teamwork was not visible to them. As all of the research included in these studies was based on an interprofessional approach we accept and appreciate that team working (networking, coordination, collaboration, or teamwork) was a part of the client care. However this client visibility aspect of the team mechanisms of the care has prompted a new categorization of the interprofessional approach that could be considered to be 'front of house' being present or visible to the client, and 'back of house' happening behind the scenes in preparation or as an activity that supports the client care.

The front of house activities observed by the clients provided the setting for most of the feedback reported from the clients including feedback of communication, client centered care, and the client experience of joint therapeutic sessions. Within the communication and client centered themes the reported facilitators to care

were notably ones that are valued as part of an interprofessional approach, such as empowering, listening to and respecting the client, and being treated with kindness in a non-judgmental way. The reported barriers to communication were most common within the group of clients from a group care interprofessional approach, suggesting that an interprofessional approach may not be effective in this care setting.

The experience of clients within a research approach that included joint therapeutic sessions was noted as being beneficial and positive by many clients. However, many general negative impressions, concerns about client privacy and that clients felt that having more than one practitioner would provide additional pressure of client adherence were also reported in this care setting. The studies which included interprofessional joint therapeutic sessions did not provide evidence that the clients had been given prior support for how to navigate the joint sessions. Despite this lack of preparation, the clients seemed to adapt to the joint sessions over the course of the interventions, with the study of O'Sullivan et al. (2018) providing insight that the joint sessions led the clients to 'feel special' and 'the centre of attention' demonstrating that the initial fear of a joint therapeutic session can transform into one of support and nurturing with experience.

This examination of the literature has so far uncovered what interprofessional practice is compared to other forms of team-based care, the framework of client-centered care and shared decision-making that are central to the application of an interprofessional practice model, and the potential for paradoxes in the application of these models. In addition, the feedback from clients in different types of interprofessional care approachs in chronic care settings was reviewed. In the

following sections, the other domains relevant to this research study are examined, being the role of community health centres in Australia and the specific nature of the client cohort included in this study program.

2.4 The role of community health centres

Primary healthcare, of which community healthcare is a significant component, is defined as treating clients who are not admitted to a hospital (Australian Government Department of Health 2018). Local physicians are the most commonly associated professional for clients with primary healthcare (Australian Institute of Health and Welfare 2016). Other professions, including nurse practitioners, community nurses, allied health professionals, routinely practice in community health centres, often in multidisciplinary teams (Steering Committee for the Review of Government Service Provision 2015). A national strategy for the community health sector does not exist in Australia, which leads to considerable variation in the services provided to each community (Roussos and Fawcett 2000, Steering Committee for the Review of Government Service Provision 2015). Community health centres are the leading provider of care for clients with chronic conditions (Paez, Zhao and Hwang 2009). The Australian government Medicare benefits scheme (the listing of services funded by the government) provides funding for individuals with complex chronic care needs to receive physician managed or team-based care planning. Practitioners can also secure the financing of case conferencing under this scheme for the time required to discuss the client's needs with other practitioners to aid in managing these clients. Practitioners in community health find it difficult to keep up with the volume of client needs, particularly for clients with chronic conditions. This overload on

demand for practitioners often leads to waitlists for appointments with some professions (Harding et al. 2018). Positive outcomes have been reported with programs that provide support to clients with self-management tools that help lessen the burden of their condition (Dineen-Griffin et al. 2019). Self-management support has also been shown to help reduce the economic impact of chronic disease, which contributes to the sustainability of community health programs (Allegrante, Wells and Peterson 2019; Beck et al. 2018; Teljeur et al. 2017).

2.4.1 Self-management strategies as community health programs

A review of self-management strategy interventions in chronic care (Dineen-Griffin et al. 2019) demonstrated that care delivered face-to-face by practitioners in community health programs could lead to improvements in clinical and quality of life outcomes. The self-management strategies that were the most successful in this study included activities that were tailored to enhance the client's self-management skill set. For example, independent monitoring of symptoms, personalised action plans, stress management strategies, and enhancing responsibility in medication adherence or lifestyle choices. Elkman et al. (2011) found that selecting strategies that met with client preferences, along with an understanding of their prior knowledge and circumstances, were vital in supporting client participation in their care. Other successful strategies included adapting interventions to the client's readiness for change and breaking down individual health goals into smaller achievable actions (Dineen-Griffin et al. 2019).

The conceptual definition of self-management interventions is generally understood to include both the transfer of knowledge (Bourbeau and van der

Palen 2009; Glasgow et al. 2003) and the active involvement of the client (Lorig and Holman 2003; Wagner 1998). Dineen-Griffin et al. (2019) state that self-management support can be viewed as both a portfolio of techniques and a collaborative partnership between the practitioner and the client. To enable active involvement, clients require persistent engagement in planning care and setting their own goals (Thórarinsdóttir et al. 2019). Active client engagement enables a greater focus on carrying out self-management activities.

In their review of self-management strategy interventions in chronic care, Dineen-Griffin et al. (2019) reported strategies aimed at increasing the client's knowledge acquisition and improving the client's decision-making skills were the most frequently reported (53.8%) with positive results (note the authors do not report the frequency of these strategies with mixed or negative results). However, a similar review in 2014 (Liddy, Blazkho and Mill 2014) reported that clients trying to deal with both physical and emotional symptoms of their chronic conditions had the most difficulty with self-management techniques even with an increase in knowledge acquisition. Both Dineen-Griffin et al. (2019) and Liddy et al. (2014) align with other researchers who report that clients grappling with physical functioning along with heightened emotional symptoms were unable to attend to normal daily activities, and this impaired their ability to successfully self-manage (e.g., Bair et al. 2019; Roberto, Gigliotti and Husser 2005; Bayliss et al. 2008). Consequently, calls have been made to increase the examination of self-management programs that include both the clinical perspective and a humanistic focus on the client (e.g., Salemonsen et al. 2020, Sezgin et al. 2020).

While most self-management support studies have identified positive outcomes for single chronic diseases (e.g. Allegrante, Wells and Peterson 2019; Chodosh et al. 2005; Jeddi, Nobovati and Amirazodi 2017), little is known about how clients might engage with self-management activities if they have been diagnosed with multi-morbidities (Contant et al. 2019; Liddy et al. 2014). Multimorbidity poses an additional challenge for self-management interventions as the effect of multimorbidity on a client is not always clearly identified. Interestingly, some studies have reported that clients with multi-morbidities have shown improvements in self-management techniques because clients felt they had needed to develop their self-management skills before starting any clinical programs (Cameron et al. 2009). Other researchers have called for further study in self-management support to examine the client's ability to self-manage over time and the effect this self-management has on diminishing the impact of the chronic condition (e.g. Jordan et al. 2008). An examination of the education practitioners receive in self-management support techniques for sustained client behaviour change is also needed (Ekman et al. 2011).

For practitioners who are members of an interprofessional team, understanding the clients' experience of support for self-management techniques may require new perspectives to be developed. The perspectives of practitioners from different professions and the ability of clients to be engaged to work together require the study of an interprofessional approach in specific healthcare settings with specific client populations. The needs of clients from refugee and asylum seeker background with complex chronic pain conditions in a community health setting offers a valuable focus for such a study.

2.5 Clients from refugee and asylum seeker background

People of refugee and asylum seeker background have been subject to persecution in their country of origin (Australian Red Cross 2020). The seeking of asylum and refuge following world atrocities, political unrest and environmental disasters is growing exponentially year on year. In 2016 more than two million new applications for asylum were received globally, adding substantially to the total 65.6 million recognised internationally (United Nations High Commissioner for Refugees 2018). In Australia, people in these circumstances may be identified and referred for resettlement by the United Nations High Commissioner for Refugees. Many clients from refugee and asylum seeker backgrounds suffer from poor mental and physical health (Yaser 2017). Some factors that contribute to these conditions include housing problems, little or no work opportunities, and ongoing trauma in their country of origin.

Additionally, those with lower educational or socioeconomic backgrounds before their displacement were reported to have a more substantial deficiency in health outcomes upon arrival in their host country (Yaser 2017). Many displaced people are unable to read or write in the language of their host country. These language barriers can exacerbate health problems and add to their social and legal concerns (Doney 2011). In Australia, free English language tuition is made available to people of refugee and asylum seeker background with up to 910 hours of language classes available for people under 25 years of age, while adults are eligible for up to 510 hours (Parliament of Australia 2014). Suitable housing in Australia for families of refugee and asylum seeker background is difficult to secure due to the size of some family groups. Government agencies provide

funding to assist with housing. However, these agencies are criticised for not covering items such as utilities, rent, and bond required to rent a property in Australia (Department of Immigration and Border Protection 2019). People of refugee and asylum seeker background struggle with navigating government departments for financial and housing assistance due to language barriers (Kinzie 2001). Feelings of isolation and loneliness due to separation from family and adapting to a new country, and feeling overwhelmed by resettlement challenges, are common amongst people of refugee and asylum seeker background (Yaser 2017). These feelings can result in a physical and psychological impact that is difficult to manage in a new environment (Babacan and Babacan 2007).

2.5.1 The prevalence of complex chronic pain conditions among clients with refugee or asylum-seeker backgrounds

Following a systematic review of the literature reporting on refugees resettled in western countries, Fazel, Wheeler and Danesh (2005) summated that 9% met the criteria for diagnosis of post-traumatic stress disorder (PTSD) and 5% with major depression, stress and anxiety. They compared age-matched general populations with refugees resettled in western countries and found refugees could be ten times more likely to have PTSD (Fazel et al., 2005). Additionally, Liedl and Knaevelsrud (2008) reported that 80% of people from a refugee or asylum-seeking background experience chronic pain. This combination of complex and interconnected experiences can include the physical and psychological response to torture and trauma, physical deprivation and injury, and psychosomatic disorders (Krippner, Pitchford and Davies 2012). Chronic pain is recognised to be any pain that persists for more than three months post the initial injury that may

have been responsible for causing the pain (Tompkins, Hobelmann and Compton 2017) and is a significant contributor to much suffering and disability. It is commonly associated with experiences of depression, sleep disturbance, fatigue, and decreased overall physical and mental functioning (Amtmann et al. 2015).

The term PTSD was first officially used in 1977 by the World Health Organization (International Statistical Classification of Diseases and Related Health Problems, 9th edition 1977) and 1980 by the American Psychiatric Association (Diagnostic and Statistical Manual of Mental Disorders, 3rd edition 1980). While these classification systems are used throughout the world, they reflect Western cultural beliefs about human nature (Krippner et al. 2012) and culture needs to be considered in the diagnosis and treatment. The accepted model of simple PTSD (compared to more complex PTSD conditions where additional symptoms may be experienced such as: difficulty controlling emotions) consigns the traumatic experience to the past, implying the trauma was something experienced before or during flight. There are no reports of comparing the presence of simple compared to complex PTSD amongst clients of refugee and asylum-seeker background. However, it is now acknowledged for clients of refugee and asylum-seeker background that trauma can also be experienced in their country of resettlement, through isolation, violence, and racism (Ellis et al. 2019; Valibhov, Kaplan and Szwarc 2017; Weaver and Burns 2001).

Overall, those with chronic pain tend to have higher incidences of mood disorders (i.e. anxiety, depression) and programs often use strengthening techniques that include strategies for increasing self-management capacity (e.g. Lawn and Schoo 2010; Polacsek, Boardman and McCann 2021; Reid et al. 2008). These self-

management techniques require the client to develop self-determination and self-efficacy through empowerment (Edner et al. 2018; Gillison et al. 2019; Pignataro and Huddleston 2015). They are often termed socio-ethical techniques for this reason and require both a physical and mental health therapeutic approach. However, those from a refugee and asylum seeker background often hold cultural beliefs that stigmatise mental health difficulties.

People's cultural background may influence many different social connections in their day-to-day interactions (Ting-Toomey and Dorjee 2018). Some of these social connections include the person's identity, experiences, and capacities in different environments and how they relate to others, for example, gender, education, family, and cultural beliefs. Sheikh and Furnham (2000) demonstrated how people from different cultures explain mental distress to be tightly coupled to their cultural context by comparing results of a mental distress questionnaire from different groups of clients with British Asian, western European and Pakistani background. There were significant differences between the three groups in the causal attributions of mental distress. In turn, these individual contexts may impact how people describe the causes of their own and others' behaviours in relation to existing chronic conditions. Furthermore, social context often influences the pattern of help-seeking for people of refugee and asylum seeker background, which is important to understand in the care setting (Grupp et al. 2019; Kienzler, Spence and Wenzel 2019). Few reports have looked to identify the difference in attitudes towards seeking help through physical therapy or psychological care such as counselling in these populations. However, physical pain is one of the most common reasons for seeking medical attention for people

in the general population in Western cultures (Hom, Stanley and Joiner 2015; Yousaf, Grunfeld and Hunter 2015).

2.6 Selecting a methodology and research focus

This program provided a unique opportunity to explore in detail the application of an interprofessional practice approach in this clinical care setting. The methodologies of similar studies utilising an interprofessional approach were investigated to determine if they would also be suitable for this study. For example, Elwyn et al. (1999), and Loh et al. (2007), have examined practitioners working in interprofessional teams and their clients. However, the study of Elwyn et al. (1999) only focused on the moment of shared decision-making between the practitioner and client in a clinical session. These researchers utilised focus groups with practitioners providing them with vignettes of simulated practitioner-client interactions. The analysis of the transcripts from the focus groups was theme based, which did not allow a granular exploration of the individual practitioner's experience as this current study aims to provide. The methodology of Loh et al. (2007) was also reviewed. These researchers utilised a randomised controlled trial to determine the effects and costs of an interprofessional approach in a specific care setting. The methodology chosen for a randomised controlled trial by Loh et al. (2007) was not compatible with this current study's aim as a control group was not available.

Indeed, in a review of studies focusing on the practitioner and client experience in an interprofessional care setting, Shay and Lafata (2015) reported that the majority, including Elwyn et al. (1999) and Loh et al. (2007), focused on the use of a cognitive-affective measure, for example, satisfaction with care, concern/anxiety

about illness, and satisfaction with care decisions (e.g. Gattellari, Butow and Tatersall 2001, Golin et al. 2002; Keating et al. 2002). These studies did not investigate the experience of participating in an interprofessional care setting.

These earlier studies did not explore the development of a therapeutic relationship between the practitioners and clients, which is one of the critical areas of interest for this study. Therefore, it was determined that a different approach that would allow the specific study of lived experience should enhance our understanding of the interactions between practitioners and between practitioners and clients within an interprofessional practice in chronic care settings. A qualitative methodology was determined as appropriate as it would allow the capture of an intricate array of everyday experiences (Creswell et al. 2018; Suzuki et al. 2007; van Manen 2016).

Several qualitative approaches were considered, which may offer a variety of insights. A grounded theory approach is a qualitative approach that involves constructing theories through gathering and analysing data (Martin and Turner 1986; Strauss and Corbin 1994). Grounded theory is an appropriate choice of method to explore social and health sciences, as the aims of this approach are often to establish a model that can be applied to understand and explain how something works. However, developing a model or understanding mechanisms of interaction was not a goal of this current research. Within this research, knowledge of the subject is limited, and new insights can be beneficial, so the focus was on the lived experience of the participants to help illuminate how practitioners and clients felt while interacting in this healthcare approach. Therefore, the nature of a grounded theory approach made it inappropriate for this current study.

A case study approach is another qualitative methodology applied within this research area and was initially utilised during the data collection phase. A case study methodology aims to explore a small number of cases in considerable depth with data from multiple sources or a multi-dimensional form of data collection (Tritter 2007; Hesse-Biber and Leavy 2011). A case study is an appropriate choice when the field is not well understood (Keates et al. 2000) and when the study anticipates only a small number of participants (Baškarada 2014). As the evaluation of this current research progressed, it was determined that limiting to only a few participants would leave the study vulnerable to participant dropout as clients of refugee and asylum seeker background have a variable visa certainty. Another limitation was the inability to source client data from multiple sources, a crucial component of a case study analysis. Clients of refugee and asylum seeker background are reluctant to confide in authorities or provide consent to use documentation relating to their healthcare due to their visa uncertainly (Eisold 2019). Initially, the research proceeded using a case study framework. However, it became clear that due to the limitations of access to various forms of documentation from the clients, an individual case study approach was not going to be possible. After some consideration it became clear that a phenomenological approach would be more suitable.

Phenomenology is a form of qualitative research that explores an individual's lived experiences (Adu 2019; Alase 2017; Qutoshi 2018). A phenomenological enquiry is conducted without theories about the causal explanation of experiences (i.e. mechanisms and processes). As phenomenology utilises an approach that incorporates an in-depth study of written transcripts of interviews, it does not require additional information about the participants from other sources. In this

current study, the benefits of using a phenomenological approach included that only small numbers of participants would be necessary. Therefore, it was determined that a phenomenological approach was a suitable methodology that could be utilised with the identified limitations of this study.

Different types of phenomenological methodologies inquire into individuals' experience in learning more about complex issues that may not be immediately implicit in participants' dialogue. There are two main approaches phenomenologists use to understand these hidden forms of experience: descriptive and interpretive. A descriptive phenomenologist explores and describes the lived experience without ascribing meaning (Charlick et al. 2016). Bracketing, or epoché, is applied to reduce the influence of the researcher's prior knowledge in this process. On the other hand, interpretive phenomenologists embrace the researcher's prior knowledge and view the participant and researcher as co-creators of interpretation (Wojnar and Swanson 2007). For this current study, IPA was chosen because it moves beyond a pure description of the participants experience to explore a deeper meaning of their involvement in an event. This interpretation of meaning is vital in the examination of the research question.

IPA focuses on developing themes from the participant's accounts of their lived experience of the phenomenon (Smith, Flowers and Larkin 2009). IPA brings an idiographic focus (emphasising the unique personal experience of human nature) to the examination of experience. This idiographic focus aims to offer insights into how individuals, in a given context, make sense of a specific situation or event in their lives (e.g. Kelly et al. 2018; Marks, Smith and McKenna 2019; Semlyen, Ali

and Flowers 2018). Thus, the IPA approach seemed to be the most appropriate methodology to explore the experiences of a team working in this client cohort. Chapters Three and Four describe the methodology and methods used in this study, including the back alignment undertaken to assess the study as phenomenological in place of a case study after the research interviews had been conducted.

Having identified IPA as the methodology, the next step was to align this methodology with the research aim. The primary purpose of this study is to explore the day-to-day experience of participating in a healthcare setting that includes an interprofessional approach from the perspectives of the practitioners and clients. Therefore, this study aims to explore what it is like for practitioners and clients to work in a team to deliver care that includes joint therapeutic sessions in an interprofessional practice approach.

Borg Xuereb, Shaw and Lane (2016) undertook a similarly complex study using an IPA approach. These researchers examined practitioner's and client's experiences of shared decision-making in clinical consultation. Borg Xuereb et al. (2016) reported that the benefits of an IPA approach were that it enabled them to prioritise the description of "*how the phenomenon of the diagnostic consultation appears to individuals coming at it from different perspectives*" (p. 440). The research design and focus were similar to the focus of this current study; therefore, a similar methodology was deemed appropriate.

At the core of IPA is a clearly stated emphasis on the experience (preconceptions) of the persons taking part in the study. As the researcher is also one of the persons necessarily present in the interview stage of the data collection and the

data analysis, the background and experience of the researcher must be declared and situated in the interpretation of the results in a process known as reflexivity (Creswell and Poth 2016). For this purpose, my experience working in programs with teams of professionals and as a researcher in healthcare is clearly stated in the prologue of this thesis. My position within the interpretation of the results is provided in the methodology section in Chapter Three and the methods section in Chapter Four. The sections in Chapter Three also provide an insight into my worldview and how this has been shaped by this research program and the philosophers who reflect the traditions of IPA. Chapter Seven concludes with a section on the reflexivity of the IPA approach for this study.

2.7 Determination of the research questions and study aims

Previous qualitative research in interprofessional practice has often focused on individual interactions in an interprofessional context (e.g. Flood et al. 2019). Alternatively, some studies have taken the form of hermeneutic analysis of transcripts of interviews of the participants who all participated in the same interprofessional practice health setting (e.g. O'Sullivan et al. 2018). However, they have not explored taking part in an interprofessional practice approach specifically as someone with complex chronic pain or as a person of refugee or asylum seeker background.

A new research direction may embrace the idiographic to balance the existing quantitative and qualitative approaches, which in isolation are limited in their capacity to understand the nature of these experiences deeply. Utilising IPA will enable an exploration of the complexities of the lived experiences surrounding an interprofessional practice approach. IPA will enable a deeper understanding of

the nature of interprofessional practice in a specific clinical setting and serve to explore and identify the essential structure and meanings tied to practitioners and clients working together in this way.

The following methodological question will be examined along the course of this investigation:

> *'Is an interprofessional practice approach in healthcare a phenomenon?*'

This question relates to the applicability of interprofessional practice to an examination as a phenomenon, and therefore the use of IPA to illuminate meaning within this phenomenon. Then, through the IPA, one overarching research question is being addressed in this study.

The overarching research question is:

> *'How do practitioners and clients make sense of the experience of being part of an interprofessional team?'*

This research question will help guide the examination of rich data by using the focus of how practitioners and clients are making sense of interacting with each other as part of a phenomenon of a healthcare setting utilising an interprofessional practice approach.

These interrelated research and methodological questions will allow the emergence of convergent and divergent themes relating to the practitioner's and clients experience working in a healthcare setting that includes an interprofessional practice approach. The multi-perspectival approach to this research will also provide the opportunity to assess the triangulation of practitioner

and client accounts of their experience to add further depth to our understanding of interprofessional practice in this clinical context.

2.8 Summary of this chapter

A single set of parameters cannot define interprofessional practice. Instead, the practice of being interprofessional stems from a set of principles and values and a philosophy driven by client-centered care. The integration of the client's clinical, physical, mental, and social needs is the basis for client-centered care. Furthermore, shared decision-making is a cornerstone of client-centered care that must include a balance of information used in making decisions, including the client's biomedical and psychosocial needs as part of the decision. Reeves et al. (2018) expanded the understanding of interprofessional practice to include four types of practice: networking, coordination, collaboration, and teamwork. Practitioners working in each of these different types of interprofessional approach may require different strategies for the engagement of clients in shared decision-making.

Recently studies have investigated the spirit that practitioners bring to working in an interprofessional team. This spirit comes with the practitioners, is shared within the team, and enhances the way of working. Understanding and examining the lived experience of those called to be part of an interprofessional practice approach will further illuminate this spirit.

Understanding the clinical needs of clients in the local community is an essential function of community healthcare. For an interprofessional practice approach to

be successful in a community healthcare environment, the local community's specific needs must be central to the development of the intervention. Care is required in the development of the interprofessional practice team. The assignment of team members (e.g. which professions based on client need), the mechanisms practitioners use in practice, and the type of interprofessional approach that is most likely to meet the needs of the client are all part of determining the right healthcare program. For clients of refugee and asylum seeker background, these needs include cultural competency to ensure the different values and beliefs of the individual clients are understood and integrated within service delivery.

This study aims to examine the lived experience of practitioners and clients in an interprofessional approach to care with clients of refugee and asylum seeker background who have been diagnosed with comorbidities that include chronic pain and mental health conditions. The study aims to illuminate the essence the practitioners and clients have in working together. Exploring the communication mechanisms and the cultural competency of the interprofessional team members in working with these clients is also a key focus of the research.

Chapter Three: Methodology

This chapter defines the concepts of research philosophy, ontology, and epistemology in developing a research worldview and applications to this thesis. Three research paradigms are then explored as approaches to interprofessional practice with their respective benefits and barriers. The researcher's view is considered through a philosophical lens, along with the influences guiding the interpretative phenomenological analysis as the approach for this thesis.

3.1 The research philosophy

Research is more than just answering questions. Research is undertaken before even knowing what questions to ask. Research is also about being inquisitive and trying to understand the world around us and how it relates to us, and research is about observing and interpreting that world. Methods and methodologies are guides to help researchers translate their research into forms that others can

understand. Sharing research methods and outcomes and allowing research progression on the back of what has been done before are the pillars that enable research advancement. For a researcher to incorporate the methods or findings of another researcher into their own, they must be able to fully comprehend and have means of evaluating the studies of others. The chosen methodology depends on the type of study, what is needed to be known, and the researchers' beliefs about how reality and knowledge should be constructed from all the available forms. These beliefs are known as the researcher's ontology and epistemology. The path the researcher chooses to take will influence their perspective and becomes their worldview - their philosophy to the research. This chapter aims to explore and acknowledge the researcher's philosophy that guided this body of research. In doing so, the steps taken in the development of the research question are revealed, along with the worldview principles that guided this path.

3.2 The research paradigm

Research paradigms can be categorised by examining their ontology, epistemology, and methodology. Ontology is the study of which lens individuals use to understand their existence. The lens can change over time (Hwang and Colyvas 2020), influenced by factors in the life of the individual (for example, the death of a child can change an individual's trust in religion) or by changes in the way society around them understands things to be accurate, or factual (for example the world being round instead of flat). In simple form, there are two beliefs or theoretical contexts in ontology, objective and subjective. An objective ontology considers an individual's view as separate from any social influences or

personal beliefs; this view is also known as the etic perspective (Killan 2013). In contrast, a subjective ontology begins with how the individual understands the meaning of the world around them as their involvement shapes it; this view is also known as the emic perspective (Killan 2013).

Most researchers fall on a spectrum somewhere between these two opposing understandings of existence. Each individual's lens is personal and includes elements of how they believe their actions shape the world around them, as well as how the world around them shapes their existence (Olson 1995).

The researcher's ontology in developing the research approach for this study was both objective and subjective. For example, the research focus may investigate the outcomes of an interprofessional approach on an individual (objective) or from the perspective of an individual and what influence they have on an interprofessional approach (subjective). With this mix of ontological approach a study of interprofessional practice may investigate how an interprofessional practice approach shapes the outcomes for an individual (objective) as well as how the individual members of the interprofessional team shape the practice approach (subjective).

Epistemology is the theory of the nature of knowledge. It is a branch of philosophy that helps us to understand and study what we know, how we know what we know, and how that knowledge is validated (Schultz and Meleis 1988). Epistemology attempts to answer questions about our understanding of where knowledge comes from, what it is, what it is not, and how we might apply methods to gain the type of knowledge that is desirable. Social epistemology is a branch of epistemology relevant to this study of interprofessional practice, as it arises from

the properties of individuals and their relations with others (Haddock, Millar and Pritchard 2010). A simple example of social epistemology provided by Haddock et al. (2010) is "*The transmission of knowledge or justification from one person to another*" (p. 3). The individual learning mechanism within an interprofessional practice approach purports that team members learn *'with, from and about'* each other. These three knowledge structures are determinants of the social epistemology of interprofessional practice.

The methodology is the third component of categorising a research paradigm. Each methodology has a system of principles and methods used for carrying out the research. The methodology is the justification for using a particular research method, which is a crucial factor in allowing the reader to evaluate the overall validity and reliability of the study. Research is about exploring the data gathered and telling the story of the data using the chosen methodology. In social research, such as healthcare, the research is a moral act, in which the researcher has the responsibility of telling the research story for the social '*good*' (Piper and Simons 2005). Storytelling is a device used to enhance a sense of persuasion of the merits of the research. Storytelling is often considered based on its arguments, which must develop from the research description to the conclusions. The methodological approach used in the research must provide a clear framework of for the analysis and presentation of the study. This framework helps the researcher avoid harm within the study design, both directly to individual participants and indirectly by the persuasive use of the findings in developing arguments and discussion (Clough and Nutbrown 2012). For example, the choices made in the number and type of participants and the methods used to gather the data for the study must align within the selected methodology. The

methodology, in turn, ensures that the study can be validated as suitable in its ability to support the persuasive storytelling of the research.

The development of a worldview brings together the researchers chosen ontology, epistemology, and methodology to create a framework for approaching a body of work. This research worldview can change over time, just as an individual's worldview can change if their opinions, beliefs, and certainties change. Therefore, the research worldview is held at a particular moment in time when certain things are known and not known, explored, and not explored.

The prologue prior to Chapter One of this thesis provided a view of my position as the researcher within this body of research. This introduction to the research included my reasons for undertaking this study and my intended path for sharing the wisdom gained. While my intentions did not vary throughout this journey, my research worldview changed after reflecting on the data collected during the study. In this reflection, I discovered that my initial methodological approach was not aligned with a worldview of how the participants described their experiences to me within the interviews; thus, it did not feel as if it was an authentic and in-depth representation of their perceptions. My way of looking at the research problem moved from a positivist to an interpretative lens. The methodology initially driving the research was a critical case study approach intended to explore the presence or absence of barriers and facilitators in a specific interprofessional practice healthcare setting. At this time, I reflected on the use of polarising the data in this way and felt it was too limiting. Some information, which seemed to be key components of the participants experience, did not fall neatly into being categorised as a facilitator or a barrier to the interprofessional practice approach.

So, I decided to review other methodological approaches which could allow all of the data to be analysed without such categorisations.

Following my decision to change this methodology, the research utilised a qualitative approach that focused on the rich data of a shared experience of the study setting. The transformation took place first in my thinking about the research and my worldview; and then the new methodological approach was applied to the data already collected, with careful attention to any issues created by this change in methodological application.

At the beginning of my research journey, I made attempts to understand why the interprofessional program approach, that forms the basis for this thesis, was successful for some clients and not for others. To this end, I examined the mechanisms being used by the practitioners in their interprofessional practice. I also noted the support and advocacy the practitioners were providing to the clients and tried to distil why this was different in the Branching Out program to therapeutic care settings that do not include an interprofessional approach. These early attempts at analysing the data were interesting, but the investigation was not satisfying in terms of revealing the authentic experience of the participants. Therefore, I went back to the beginning of the research journey, clarified the research question I was addressing with the study and then matched the methodology applied to this research goal. Once the connection was made that a phenomenological approach would be more appropriate for this study than the original case study approach, an alignment of the research aims with the philosophy and methodology of phenomenology fit naturally with the research goal. In the sections below, methodological approaches that could be applied to a

study of in interprofessional practice are examined using the postpositivism, critical theory and constructivism paradigms as I explored these alternative approaches in relation to this study.

3.2.1 A postpositivist paradigm

A postpositivist paradigm, and its preceding positivist paradigm, have the primary purpose of explaining. The explanation aims to predict phenomena, so planning can be put in place on how to work within the bounds of the phenomenon (Guba and Lincoln 1994). Karl Popper (1934/1959) was one of the first philosophers to challenge the positivist paradigm with his approach of falsification in place of verification, arguing that it is impossible to verify beliefs about things that are universal or not observable. Using this falsification approach Popper provided a distinction between positivist and postpositivist paradigms. Thus, positivists propose that reality can be something we can touch, feel, count, measure, and be accurately recorded by objective processes (verified). In contrast, postpositivists recognise that attempts to measure reality are an illusion due to variations brought about by human interpretations (Guba and Lincoln 1994), and so must be challenged to determine if they can be falsified.

Many health researchers employ a postpositivist approach (Parry, Gnich and Platt 2001). For example, a postpositivist approach to interprofessional practice may be used to search for a stable set of traits, behaviours and expectations of the practitioners who are participating in the health setting that can be measured, counted, and validated in order to be shared with others (e.g. Kenaszchuk et al. 2010). This type of study would utilise an objective ontology. In this way, a

definition of proficiency in interprofessional practice may provide a framework holding accurate knowledge about specific ways of acting in any teamwork situation. The epistemology of a study like this is the nature of understanding how proficiency is generated. The methodology of this type of study using a postpositivist approach would rely on a systematic gathering of information in categories. The study's aim may be to develop a contingent approach to interprofessional practice. A contingent approach would be garnered by learning which characteristics are relevant to which healthcare settings, based on client needs, and applying an approach that meets these standard requirements. Postpositivists employ a range of methods to have measurements from different sources that can be compared, which may include quantitative methods but may also employ qualitative methods to confirm and enrich quantitative findings (Mertens 2014).

There are two limitations to a postpositivist perspective discussed in the literature, which may be relevant to a study of interprofessional practice. First, researchers in cultural competency, a field closely aligned to interprofessional practice, who have employed a postpositivist approach have found knowledge of this type can lead to social stereotyping (a bias against certain groups in society) (Williams 2006). Second, the research that drives this paradigm generally originates from a Euro-American centered model of existence (Kristensen and Zhang 2018; Scheurich 1995; Williams 2006). This culturally biased view of research can lead to inaccurate and nonrepresentative findings (a tendency to judge people in terms of cultural assumptions) and was therefore determined not to be a suitable methodological approach for this current study.

3.2.2 A critical theory paradigm

Critical theory questions the assumptions and purposes of existing social paradigms through historicity, politics, and social constructs (Guba and Lincoln 1994). This approach was developed through the ideas of Karl Marx (1818-1883) a philosopher, political theorist, and journalist (Marx, Adams and Ball 1991) and Sigmund Freud (1856-1939) an Austrian neurologist and founder of psychoanalysis (Freud, Jones and Paskauskas 1993). The Frankfurt School in Germany, established to provide critical thought on social issues (1918-1933), is also notable on advancing the paradigm of Critical Theory (capitalised when referring specifically to this school of thought) (Childers 1990).

Utilising a critical theory view of reality, society is constructed by power processes. Individuals who are marginalised are told that the processes cannot be changed; these processes are the natural course of things. Critical theory approaches not only aim to study and understand a phenomenon in an implied reality but also to critique its meaning and change its outcome (Guba and Lincoln 1994). Critical theory is aligned with many health providers social mandate as this approach has moral objectives, as described by Swartz (2014),

> "*Critical theory searches for contradictions in social arrangements that systematically exclude groups from power or access to information*" (p. 271).

A critical theory approach to exploring interprofessional practice might investigate how false ideologies (for example, racism, sexism) misrepresent shared decision-making. From an ontological perspective, a study of this nature would be

objective, examining things that exist in reality. From an epistemological perspective, it would investigate knowledge generated within the social construct. The methods critical theorists use must be capable of illuminating oppressive constraints. These investigations would aim to identify the meanings that need to change and the actions that need to be taken to reduce these illusions in experience (Dunphy and Longo 2007).

However, the critical theory paradigm can be contradictory to other priorities. For example, applied to exploring practitioners experience in a health setting, this research view may oppose systems or processes that present barriers to selecting and incorporating appropriate team members who align with the needs of the client. Research of this type may be valid; however, the systems and processes in place may have other determinants that weigh up their balance of good for the organisation. For example, team members may be responsible for being cost-efficient or conforming to organisational policies such as gender balance and psychological safety. These responsibilities may conflict with the recommendations of critical analysis that a specific profession be included in the client's care team, being in the client's best interests but not the best interests of the practitioners or the organisation. Thus, conflicts may arise when a critical analysis is inconsistent with local policy imperatives or global healthcare concerns, making the findings of this type of research too narrow to benefit the field of study. The critical theory paradigm was not considered to be a good fit for this current study because of the focus on polarisation of inquiry required in utilising a critical theory approach, where polarisation of facilitators and barriers was what I was trying to avoid in determining a new methodological approach.

3.2.3 A constructivist paradigm

A constructivist paradigm aims to understand reality through social interaction. The constructivist view was developed by Jean Piaget (1896-1980) during his life's work in the education of children but did not become widely understood until the 1960's (Hsueh 2009) when his work developed into a sub-discipline in psychology. The central focus of a constructivist paradigm is on bringing together the holistic and often conflicting realities of research subjects and the researcher to reconstruct their understandings of phenomena (a relative ontology). The shared experiences become what we know as knowledge (social epistemology). The constructed meanings are complex and varied, requiring the researcher to examine the complexities of the perspectives rather than reducing them (Creswell 2011). Constructivism varies from postpositivism and critical theory in its ontology to shift away from realism (things that exist) to relativism (multiple constructions of reality can exist).

For a study of interprofessional practice, a constructivist paradigm may take a hermeneutic approach. This approach requires illuminating meaning embedded in dialogue that must be uncovered through reflection (Orland-Barak 2006). Constructivists search for convergent and divergent subthemes in the dialogue under study. These ideas are allowed to bring contradictory meanings and perspectives without either being diminished (Ponterotto 2005). When considering a constructivist approach to a study of interprofessional practice, one way of doing this is to apply a hermeneutic analysis to participants' stories from individual interactions in an interprofessional context (e.g. Flood et al. 2019). Alternatively, it may take the form of hermeneutic analysis of transcripts of interviews of the

participants who all participated in the same interprofessional practice health setting (e.g. O'Sullivan et al. 2018). Quantitative methods, such as surveys or measures of outcomes, can be used in harmony with this research approach to validate or triangulate qualitative findings (Ford-Gilboe et al. 1995). Therefore, illuminated through a constructivist lens, examining an interprofessional practice approach would define a set of identified experiences and personal expectations used to make sense of the world. To gain an accurate understanding of the nature of being interprofessional, researchers using this approach must be prepared to engage with the individual and their distinctive account of what is significant and necessary. Constructivist approaches are highly relevant to the development of knowledge related to how practitioners and clients make meaning of being part of an interprofessional practice care team. Therefore, as I was searching for a methodological approach that would allow a wide range of different meanings of an interprofessional approach to emerge from the data a constructivist approach was considered to be the most appropriate for this current study.

3.3 Comparing different constructivist approaches

Once a determination of applying a constructivist approach to the study was made a comparison of different types of this approach was undertaken. The three approaches reviewed were narrative psychology, thematic analysis and interpretative phenomenological analysis (IPA). Each of these approaches is discussed below.

3.3.1 Narrative psychology

An individual's experience is told and retold through the construction of stories which help them to deal with the experience and share these experiences with others. Narrative psychology is a social constructist approach that studies the implications of these stories of individuals experience for the individual and society (Crossley 2000). Narrative psychologists use interviews to provide an opportunity for a person to give a detailed account of their life or particular events through the construct of telling the experience through a story-based response. Narratives can then be transcribed and analysed in order to be interpreted (Murray 2015).

Narrative psychology was not available to be utilised in this study as the interviews with the clients and practitioners had already taken place and participants were not available to be re-interviewed.

3.3.2 Thematic analysis

Thematic analysis is a method for identifying, analysing and interpreting patterns of meaning ('themes') within qualitative data (Clarke and Braun 2014). Thematic analysis can be applied across a range of theoretical frameworks and research paradigms. There are also versions of thematic analysis developed (primarily) for use within a qualitative paradigm (Braun & Clarke, 2006, 2013). These versions emphasise an organic approach to coding and theme development and the active role of the researcher in these processes (e.g., Holmqvist & Frisén, 2012).

The aim of thematic analysis is not simply to summarise the data content, but to identify, and interpret, key, but not necessarily all, features of the data, guided by

the research question. However, within thematic analysis, the research question is not fixed and can evolve throughout coding and theme development.

Thematic analysis can be used to identify patterns within and across data in relation to participants' lived experience, views and perspectives, and behaviour and practices and within 'experiential' research which seeks to understand what participants' think, feel and do. Thematic analysis is distinguished from most other qualitative analytic approaches by its flexibility, leading to a wide range of applications (Clarke and Braun 2014).. Combined with its accessibility, this makes it attractive to qualitative researchers in positive psychology, with their wide range of concerns, and particularly to researchers in the field new to qualitative research and those seeking qualitative methods.

Thematic analysis is a methodology that could be utilised for this study but was determined not to be the most suitable as it lacked the focus on the individual participants that could be offered by interpretative phenomenological analysis.

3.3.3 Interpretative phenomenological analysis

Interpretative phenomenological analysis (IPA) is an approach to psychological qualitative research with an idiographic focus, which means that it aims to offer insights into how a given person, in a given context, makes sense of a given phenomenon. Participants are invited to take part precisely because they can offer the researcher some meaningful insight into the topic of the study (purposive sampling). Usually, participants in an IPA study are expected to have certain experiences in common with one another: the small-scale nature of a basic IPA study shows how something is understood in a given context, and from a

shared perspective. More advanced IPA study designs may draw together samples which offer multiple perspectives on a shared experience (husbands and wives, for example, or psychiatrists and patients). An IPA approach was considered to align with the research question of this current study most closely.

3.4 Aligning the research question with the research paradigm

The exploration provided above of how different research paradigms can help uncover aspects of interprofessional practice is vital in choosing the right direction for this study. Each philosophical paradigm has its place in this field and can help to answer different research questions. Multiple approaches are paramount to understand the full nature of what it means to be utilising an interprofessional approach to healthcare. Therefore, it is important to focus specifically on the research question for this study, as outlined in Chapter One, and the paradigm that aligns with the aims that direct this question.

This study addresses a gap in how a specific interprofessional approach that includes joint therapeutic sessions is interpreted by the practitioners and clients who participate in the interprofessional activities together. One of the general problems addressed in this study is understanding how practitioners make sense of the experience of interprofessional practice in promoting mutual trust between teams of practitioners and their clients. As trust is a difficult concept to measure, researchers examine the dialogue between people to understand how trust develops (e.g. Aitken, Cunningham-Burley and Pagliari 2016; DeJonckheere and Vaughn 2019; Lane and Kent 2018). Therefore, understanding the development of mutual trust in interprofessional practice requires the illumination of meaning in the dialogue and actions between practitioners within the team and between

practitioners with their clients. Of note, it was only after the data collection phase of this current study that my awareness of a misalignment between the research question and the case study methodology that had been used to design the interview questions. Despite many meetings with my supervisors over the time of initial research design this misalignment was not picked up until the stage of presenting the emerging work in a formal forum with my primary supervisor and two independent reviewers. At this time the decision was made to re-evaluate the methodology utilised in the study, and also to change the format of the thesis from a thesis by publication to a traditional structure.

Had this shift come earlier in the design of this study the data collection may have been undertaken in a different style of interview. The main differences in these two approaches to interview style are that in a critical case study the interview may followed a more scripted style, with prompts to help the participant to reveal in-depth information on a particular issue. While an IPA style interview does not use prompting, the interviewer allows the participant time to reflect on questions allowing their own meaning making to be illuminated when they are able to do so.

However, post the data collection phase the methodology selected for this study was an IPA approach, which utilises a hermeneutic-constructivist view. The hermeneutic focus will allow the examination of the ideas and insights that have come from those with lived experience. Simultaneously, a constructivist paradigm will enable convergent and divergent ideas to emerge through the exploration. van Manen (1990) explains that,

> "*A good [phenomenological] description that constitutes the essence of something is construed so that the structure of a lived experience is*

revealed to us in such a way that we are now able to grasp the nature and significance of this experience in a hitherto unseen way" (p. 39).

Being sensitive to the nature of interprofessional practice and its variabilities in practitioner competencies and client needs requires a detailed study of how individuals make meaning within this phenomenon to allow new understandings to emerge about the connections within the team that are the backbone of the therapeutic relationship. In utilising an IPA approach to help understand the meanings embedded in the participants interviews in this study, the hope is that nuances of meaning will come to light that would normally not emerge in a more polarised analysis (eg. Thematic analysis exploring facilitators and benefits).

IPA was chosen for its focus on the relationships between the parts and the whole of a lived experience (Smith and Shinebourne 2012). This focus is fundamental in examining how the practitioners elucidate the beneficence of the experience where beneficence, and its ethical partner non-maleficence, weigh up the benefits and risks that the experience will produce for the client (Tjeltveit 2006). Another specific problem to be examined in this study is the notion of cultural complexity in interprofessional practice. Practitioners who are working with clients from refugee and asylum seeker background, such as in this current study need to be aware of the need for cultural and population-based treatments. The idiographic construct (focus on individuals) within IPA will allow the development of insights into how the practitioners and clients in this study make sense of the experience of an interprofessional team. As each client has a different cultural background and brings their own beliefs and understanding of their world into the interprofessional experience, the research needs to take the time to dwell and reflect on each

practitioner in the team and each client in this idiographic way. The strengths, criticisms and conundrums of IPA are examined in more detail below.

3.5 The development of interpretative phenomenological analysis

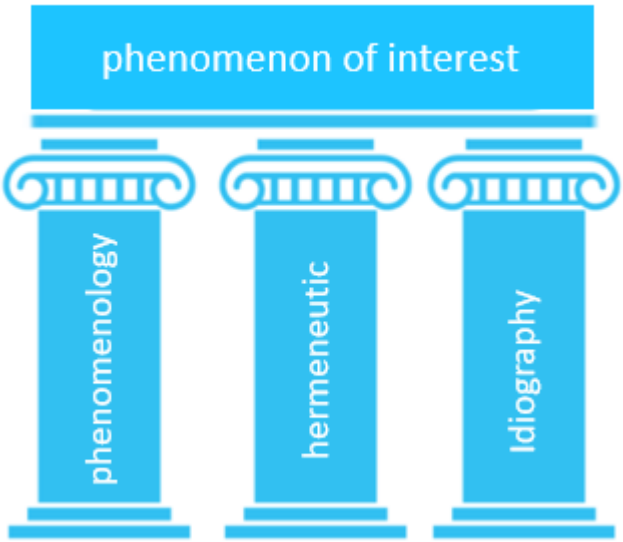
IPA is a tradition built on the traditions of phenomenologists, psychologists and philosophers that came before and continue to challenge this methodology. The IPA approach was developed in the 1990s by Jonathan Smith and colleagues at Birkbeck University in the United Kingdom (Smith, Flowers and Larkin 2009), explicitly as "*A psychological methodology concerned with the detailed exploration of individual experience*" (Smith 2008, p. 40). The psychological origin helps enable IPA to complement quantitative psychological research, as aspects of IPA may be informed by direct engagement with existing theoretical constructs or directed towards a preformed research question (Larkin, Watts and Clifton 2006). However, this link to psychological theories and specifically directed research questions has also brought the most contention in terms of IPA's claims to phenomenology, as some researchers claim these inherent origins of IPA are paradoxes to phenomenological attitude (e.g. van Manen 2017). An argument that is dismissed by Smith (2018) and explored further in section 3.4.5 of this Chapter.

The theoretical underpinnings of IPA are phenomenology, hermeneutics and idiography. IPA is phenomenological in its approach to initially bracket preconceptions (putting existing knowledge and thoughts of a phenomenon to one side), allowing the phenomenon to be understood more clearly. At the same time, it is hermeneutic in its interpretation of subjects who recall experiences of a phenomenon. In IPA, a double-hermeneutic occurs whereby,

"*The researcher is trying to make sense of the participant trying to make sense of what is happening to them*" (Smith and Osborn 2015, p 41).

Furthermore, IPA is idiographic in its relation to the interpretation of the experience of an individual before moving on to more general interpretations. These three theoretical principles of IPA may be visualised as the legs of a three-legged stool, three pillars, or three channels of investigation to help illuminate the phenomenon of interest (Behal 2017), as visualised in Figure 3.1.

Figure 3.1 The three pillars of interpretative phenomenological analysis



Undertaking a research approach utilising IPA requires an appreciation of the philosophies that underpin it (Smith et al. 2009). The foundations and beliefs of each of these philosophical pillars are described in more detail in the next sub-sections.

3.5.1 Phenomenology

While Edmund Husserl (1859 –1938) is well known as the founder of the branch of investigation known as phenomenology, his philosophy follows in the footsteps of Kant, Nietzsche and Hegel (van Manen 2017a). Husserl's development of phenomenology stemmed from attempts to construct a philosophical science of consciousness (phenomena). For Husserl, the idea of consciousness was situated within the personal experience of things that could be explained, such as events, people, objects, prejudices, perceptions, thoughts, beliefs and hopes. Husserl first developed his philosophy of phenomenology in 1914-1918, at the end of World War 1 when the doctrines of capitalism raged, and cultural values were in turmoil (Miettinen 2013). Science followed this social order of seeking and counting outcomes, emphasising positivism which disrupted many of the philosophical thinkers of the day (Eagleton 1983). Husserl sought to develop a new philosophical method within this ideological crisis that *"Would lend absolute certainty to a disintegrating civilisation*" (Eagleton 1983, p. 54).

Husserl became known for his calling to '*Zurück zu den Sachen*', *'go back to the facts'*, or *'to the thing's themselves'* (Mohanty 1970). With this new approach, Husserl brought together the natural and the empirical sciences. For Husserl, phenomenology was scientific, describing it as "*The rigorous science of all conceivable transcendental phenomena"* (Husserl 1907/1990, p. 23). The transcendental attitude is the initial step in Husserl's phenomenology process, being a compilation of empirical and natural attitudes. This empirical attitude is a mode of being free from worldly and empirical assumptions. In contrast, the

natural attitude is employed in everyday life, where objects are taken for granted as real, tangible things.

The transcendental phenomenological attitude process requires bracketing, or epoché, followed by reduction, which refers to refraining from positing existence as given, typically taking place in a natural attitude. Bracketing requires the researcher to put aside pre-conceived judgements to focus on the experience. In doing so, the researcher first acknowledges these preconceptions and then purposefully puts them to one side. In this way, the researcher allows the phenomena to come forward as if one was investigating in a foreign land (Husserl 1999). For Husserl, the fundamental property of consciousness was intentionality. The researcher is aware of something the mind is relationally directed towards (Smith and McIntyre 1982; Zahavi and Parnas 1998). Thus, intentionality is the description of the experience the study turns to in its appearance and foundation for knowledge. Husserl introduced the ideas of '*noema*' (what is thought about) and *'noesis*' (thinking about or interpreting). These terms designate the elements of the structure of an intentional act. They help researchers understand the essence of a phenomenon and when the researcher has brought interpretation to understanding the phenomenon. The researcher first considers the given, even if it is real, in the way that it presents itself to the consciousness and intentionally reduces it to a phenomenon, not a reality. The reduction allows the researcher to suspend judgements to focus on the analysis of the experience. As noted by Giorgi (2007), "*It is a reduction from existence to presence*" (p. 64).

The second step in the process of phenomenology for Husserl was the reflection. It is only in reflecting that the researcher can understand the experience. Husserl (1927) articulates the importance of reflection in this account from his explanation of phenomenology

> "*Focusing our experiencing gaze on our own psychic life necessarily takes place as reflection … Every experience can be subject to such reflection… when we are fully engaged in conscious activity, we focus exclusively on the specific thing, thoughts, values, goals or means involved, but not on the physical experience as such, in which these things are known as such. Only reflection reveals this to us. Through reflection … we grasp the corresponding subjective experiences in which we become 'conscious' of them, in which (in the broadest sense) they 'appear'. For this reason, they are called 'phenomena' and their most general essential character is to exist as the 'consciousness of', 'appearance of' the specific things thoughts (judged states of affairs, grounds, conclusions), plans, decisions, hopes, and so forth"* (p. 699).

Considered from the perspective of IPA, Smith et al. (2009) contend that,

> "*Like Husserl, we see phenomenological research as systematically and attentively reflecting on everyday lived experience. With Husserl, we see that everyday experience can be either first-order activity or second-order mental and affective responses to that activity - remembering, regretting, desiring, and so forth*" (p. 33).

Husserl's influence was passed on through tradition to Heidegger, Gadamer, Merleau-Ponty, Derrida, van Manen, Smith and others. In this way, Husserl's

conceptual vision inspired others to dig deeper into their fundamental elements of thinking.

Many of Husserl's traditions are carried through within an IPA approach; for example, the ongoing reflection on the phenomenon itself rather than the application and testing against a predetermined theory. This reflection occurs through bracketing and reduction before the analysis, allowing the focus to remain on the phenomenon. In this thesis, the phenomenon is interprofessional practice. To allow a focus on interprofessional practice as a phenomenon requires removing the clinical stories, the clinical difference between professions and the practice of therapy and concentrating on the experience of being interprofessional within the healthcare setting. Utilising an IPA approach, bracketing is also conceptualised during the analysis. Each case is reflected individually and then put to one side before analysing the next case. During the ongoing reflection of the practitioner-practitioner-client triad in this study, it was necessary to put aside expectations of how professions may come together in the engagement as reported in the literature. Bracketing practitioners from one case to another is also essential, as is bracketing the practitioner's cases before moving on to the experience of the individual client's cases. This process allows each voice to be perceived clearly from the one before.

3.5.2 Hermeneutic phenomenology

Martin Heidegger (1889-1976) was one of Husserl's students between 1909-1911 (Horrigan-Kelly, Millar and Dowling 2016). Heidegger used a hermeneutic philosophy to build on, and then critique the teachings purported by Husserl.

Hermeneutics is a study of deep and insightful interpretation, whereas Husserl's approach was purely descriptive or transcendental. Even though hermeneutics demands the researcher to interpret a text from many angles, it is acknowledged that the researcher can never reach the perfect interpretation within this principle. This limit comes because the researcher can never hold all the possible contextual factors that the person in the original experience thought or understood (e.g. Hovey et al. 2017; Neubauer, Witkop and Varpio 2019). The main disadvantage of interpretivism relates to the subjective and potentially biased nature of this approach. However, the significant levels of depth that can be achieved with this undertaking, and the high level of validity, more often than not, outweigh any negative connotations (Schick-Makaroff et al. 2016).

Heidegger was openly critical of philosophers such as Husserl for their focus on an individual's understanding of their experience, without first exploring what it means to exist or be in the world (Neubauer, Witkop and Varpio 2019; Soule and Freeman 2019). To this end, Heidegger introduced the concept of Dasein, or *'being there'*, in his revolutionary book *'Being and Time'* (1927). Dasein refers to the person who is exploring their being (Wisnewski 2012). The world around an individual is shaped by how they interact with experience and how time shapes the way they interact, thus being and time.

It can be helpful to conceptualise how others have applied Dasein to explore experience. Christopher Nolan encapsulated an exploration of being and time in his film Dunkirk in 2017 (Nicholas 2020). The film depicts the Dunkirk evacuation of World War II from three perspectives: land, sea and air, and within three critical perspectives of time. The beach is the destination for the three journeys, where

400,000 young soldiers, surrounded by the enemy, are waiting to be saved. The first perspective covers a land journey of a month where soldiers try desperately to make their way to the potential survivors. The second perspective has a civilian sailor setting out across the sea to help with the rescue. The journey is treacherous and takes a week. Three Spitfire pilots attempt to cross the English Channel to help with the effort in the third perspective. Two are shot down, but one prevails. The action covers an hour of the surviving pilot's desperate attempt to reach the beach. All three perspectives interact in the experience of the rescue, and 330,000 men are evacuated. Three journeys, three timeframes but all cover the same distance of time in the film. Thus, each perspective is bound by time and shared experience. The essential elements of this film help showcase Heidegger's concept of Dasein. An understanding which exhibits that Dasein is not just about being, it is also about being in the time that we have and the decisions we make because we have a limited time within an experience.

Another concept introduced by Heidegger was logos, which engages the question of interpretation. Logos incorporates the process of revealing and exposing that which may be hidden. Heidegger translates logos as '*discourse*' (Moran 2000, p. 229), where discourse refers to an evolutionary capacity to communicate with others, being the basis of intelligence. For Heidegger, "*The way in which discourse gets expressed is language*" (Heidegger 1962, p. 203-4). Thus '*meaning*' is the articulation of interpretation and discourse. Heidegger (1962) furthers '*meaning*' by the use of an understanding of fore-having, as such

> "*In interpreting, we do not, so to speak, throw a 'signification' over some naked thing which is present-at-hand, we do not stick a value on it; but*

> *when something within-the-world is encountered as such, the thing in question already has an involvement which is disclosed in our understanding of the world, and this involvement is one which gets laid out by the interpretation"* (p. 190).

Therefore, interpretation is already contextualised in previous experience, "*Interpretation is grounded in something we have in advance – in a fore-having*" (Heidegger 1962, p. 191).

IPA is interpretative in the action of the participant, making sense of the experience, and in the researcher making sense of the participant. Therefore, the researcher must make sense of the participant's experience through their preconception and must challenge themselves, as Finlay (2009) articulated,

> "*To critically and reflexively evaluate how these pre-understandings influence the research*" (p. 17).

Heidegger (1962) makes a point of acknowledging preconception and not falling into its trap. He states,

> *"Our first, last, and constant task in interpreting is never to allow our fore-having, fore-sight, and fore-conception to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out the fore-structures in terms of the things themselves"* (p. 195).

The hermeneutic circle is a concept often attributed to Heidegger but is based on a theologian concept of faith and reason (Westphal 2001). In biblical terms, the concept was conceived to improve the understanding and truthfulness of God (Westphal 2001). The underlying tenet remains that the hermeneutic circle binds

the parts with the whole and the whole with its underlying parts. In phenomenology, the hermeneutic circle is a process of interpretation of human experience, continually moving between smaller and larger units of meaning. Thus, interpretation through the hermeneutic circle improves our understanding of the parts and the whole. For example, the client outcomes of a care plan are not the sum of the parts of the activities documented in the plan. The meaning of outcomes is more than the parts, and the activities do not have meaning in the care plan without the context as a whole. Understanding each part one by one brings us closer to understanding the reasons for the outcome of the care plan. Nevertheless, we also need to take the care plan as a whole into account to help us understand the meaning that each of the activities brings to the goals of the plan. Heidegger envisioned that the context which determines the whole is unlimited (Thomson 2005). Each iteration of the understanding of a part is reinterpreted into the whole, revealing and interpreting the meaning of a holistic lived experience.

In both a complementary and contrasting deviation of the philosophy of Heidegger, Merleau-Ponty envisioned a *'primacy of perception'*, which states that people see the whole before the parts. Indeed, for some, the sensation of the whole cannot be detailed into parts at all (Toadvine 2016). Maurice Merleau-Ponty (1908-1961) was a French philosopher noted for his academic work in existentialism and phenomenology as much as for his influence on literature and the arts through his friendships with Jean-Paul Sartre and Simone de Beauvoir (Toadvine 2016). Among his vast literature works, he published two primary theoretical texts during his lifetime; *'The Structure of Behaviour'* (1942) and *'Phenomenology of Perception'* (1945), between them, detailing his philosophical

notions of *'primacy of perception'*, *'body schema'* (body image), *'sensory-motor unity',* and *'spatiality of situation'*. Merleau-Ponty's work is particularly relevant to a study of healthcare as his notions encompass the conflicting attitudes of the practitioner and client.

Merleau-Ponty's first assertion was that bodily senses (perception) are more important than reason (Toadvine 2016). In health practice, this notion can be related to an understanding that practitioners may see the client's condition as a series of known illness, theories, and definitions. However, the client holds an indifference towards the theoretical underpinning of health, as the client does not seek to understand their health through theories but as a whole condition affecting their wellbeing. That is, the client's perception of their condition is seen as a single perception of their bodily sensations. Merleau-Ponty's primacy of perception illuminates the multi-sensory nature of our health experience, signalling to the practitioner that a holistic view of the client's condition must include all elements of their lived experience at once.

Similarly, Merleau-Ponty proposed that since we are aware of our bodies, we relate the world to our physical capacities (Merleau-Ponty and Smith 1962). Therefore, our primary interest lies not in what the world is but instead in what we can do with the world (Toadvine 2016). Understanding these notions of perceptions and experience provides researchers with avenues into the hermeneutic circle and ways to navigate the joining of the parts with the whole. They also contribute to our preconceptions and must be considered as part of the double hermeneutic process.

In yet another deviation on Heidegger's notion of the parts and the whole, Jacques Derrida (1930-2004) introduced the concept of '*deconstruction*'. This concept has often been misunderstood to mean taking apart from the whole and examining the parts. However, Derrida's way of thinking on this matter was to deconstruct our prior understanding of the whole by dismantling our excessive loyalty to any given idea and seeing the aspects of the truth in what may lie in the opposite (Michelfelder and Palmer 1989). He challenged the privilege contained in key binary terms, such as *'men and women'* (men having privilege over women) or *'speech and text'* (the notion of speech being provided with a privilege to the written text). He even asserted that equality is not always better than inequality (Arrigo and Willams 2000). Derrida proclaimed that those who were unsure about these imbalances in binary concepts were not weak or feeble of mind but showed maturity as they struggled to comprehend both sides. The term '*aphoria*' was applied to such people searching for the truth, and for Derrida, these researchers held an *'adulthood of the mind'* (Derrida 1995).

Going back to the analogy of a care plan, for Derrida, an understanding of the outcomes of the care plan could only be achieved by releasing our preconceptions of outcomes. The activities and how the client understand them or engages in these activities need to be examined for their individual intentions of being part of the care plan. The activities may not be concerned with outcomes at all – but engagement with others (relationship building). Other activities may not be part of the care plan for discernible outcomes but instead to inspire memories of the past and help build strength to tackle problems in the present (strength building therapies). In all, the outcomes of the care plan, from the view of the parts, may not be about the perceived outcomes, even though this is a desire of the whole. If

the care plan researcher were only to consider discernible outcomes, they would miss the subtleties and richness of the meanings of the interaction between the activities in the care plan.

Derrida called researchers to consider why it might be useful, even for a little while, to be on the other side of the debate (Derrida, Porter and Morris 1983). Within this study, Derrida's challenge is essential in examining the research question – to consider how the practitioners made sense of the beneficence of the interprofessional healthcare setting. An examination of this question will require letting go of preconceptions of beneficence and assuming the position of maleficence (disruption) for a while. Taking the other side of the debate into consideration will help to reveal the parts making up this ethical consideration which may not be part of *'doing good'* but there for another reason not otherwise revealed.

Within a paradigm of IPA, the double hermeneutic is part of the hermeneutic circle, which enhances, not diminishes, the transparency of the preconceptions brought by the researcher. Smith et al. (2009) contend that the researcher must reflect on which preconceptions they bring to the interpretation. The philosophy of IPA asserts it would be a disservice to the process to bracket all preconceptions and not acknowledge the wisdom they may provide through interpretation when the time is right. Therefore, the process of interpretation in IPA is dynamic and iterative. By engaging the hermeneutic circle in this lively way, an interplay is achieved between the parts and the whole and between the interpreter and the object of interpretation. This complex and dynamic notion of pre-understanding (knowing in advance of the research study) and the relationship between the

researcher and the data creates a superlative illumination. However, the pre-understanding can never be complete, as expressed by Smith et al. (2009) as,

> "[IPA maintains] *a more enlivened form of bracketing as both a cyclical process and as something which can only be partially achieved*" (p. 25).

This philosophical understanding of the hermeneutic circle in an IPA approach also aligns with the ideology of Gadamer, which is expanded below.

Hans-Georg Gadamer (1900-2002) extended Heidegger's vision for hermeneutics by challenging the method for determining truth. In his book *'Truth and Method'* (1960) he argued that truth could not be adequately explained by the scientific method and that language transcends the limits of interpretation. For Gadamer, the preconceptions of the researcher are replaced by more suitable ones as the true meaning becomes clear. Thus, Gadamer (1960) stated,

> "*Every revision of the fore-projection is capable of projecting before itself a new projection of meaning; rival projects can emerge side by side until it becomes clearer what the unity of meaning is; interpretation begins with preconceptions that are replaced by more suitable ones. This constant process of new projection constitutes the movement of understanding and interpretation*" (p. 267).

For Gadamer, preconceptions were prejudices, but he did not hold preconceptions as a negative connotation in the way that we might understand the word prejudice (Moran 2000). Gadamer believed the history or prejudices we bring with us help us contain the whole experience to something familiar or non-threatening

(Gadamer 1990). In this way, prejudices may be understood as biases, creating preconceptions to our openness to experience.

One of the general concepts drawn from the work of Gadamer is his notion of horizons, more precisely his conviction of the *'fusion of horizons'*. Gadamer explained the horizon to be the moment in time that holds everything that is already part of prejudice and everything seen from where one stands (Gadamer 1989). Such that our horizon is continuously evolving through a process of fusion with other horizons. Thus, the horizon of the present cannot be formed without the prejudice of the past. With each experience, we are testing our prejudices and creating new ones, so for Gadamer,

> "*Understanding is always the fusion of these horizons supposedly existing by themselves"* (Gadamer 1989, p. 306)

Less discussed in the literature, but a substantial legacy from the work of Gadamer is his theory of play (Gadamer 1960). Play being the action of a particular model, or shared state, of working together. Hermeneutic phenomenology underpins play theory as being *'an understanding of knowledge creation through interaction as play'.* As people interact with each other in a co-creation of knowledge, they engage in Gadamer's idea of play (Gadamer 2004; Suorsa 2015). Gadamer describes this lively action of being together in knowledge creation as an experience of authenticity. The knowledge comes from having an openness to trust in others while being present in actions. Martin and Fonseca (2010) stated,

> "*Play, for Gadamer, is a fundamental ontology – a context for understanding all forms of presentative and communicative activity. As such, it represents the deepest reality of conversations"* (p. 261).

Gadamerian play is not a place of escaping from reality. On the contrary, for Gadamer play, "*Is a serious experience of being present"* (Gadamer 2004, p. 102). Hence, play could be seen as the activity of knowledge creation within being, creating and learning together (Suorsa 2015). The form and event of interaction, or play, has also been critical in knowledge creation (Suorsa and Huotari 2016). For this thesis, the Gadamerian theory of play closely aligns with the premise of the interprofessional practice definition of practitioner's learning *'with, from and about'* each other. The practitioners are within an act of knowledge creation by being together and being interprofessional. For Gadamer, being in play is an approach with seriousness, presence, and openness (Suorsa and Huotari 2016). Play theory within an interprofessional practice experience may provide a door for further exploration of this phenomenon.

3.5.3 Idiography

The third pillar underpinning IPA is idiography. An idiographic approach aims for a finely textured and detailed analysis of a particular case, either as an end in itself or before moving to the next case. This approach differs from an aggregated case study approach, often referred to as nomothetic research (Smith 2004). Gordon Allport is noted to have first used the terms idiographic and nomothetic in reference to phenomenology in 1937, terms he borrowed from the German philosopher Wilhelm Windelband, who published in 1894, and Hugo Münsterberg,

in 1898 (Hurlburt and Knapp 2006). Allport described nomothetic knowledge as one of the general laws (pertaining to a generality of events), and idiographic knowledge as concerned with unique events, entities, and trends (Krauss 2008). Staying close to the descriptive phenomenology developed by Husserl, the philosopher Amadeo Giorgi (1985, 1997) adhered to the establishment of the general structure, or essence, of a phenomenon. In doing so, the idiographic analysis was acknowledged to be part of the process but discarded before the essence was achieved. As stated by Finlay (2009) concerning Giorgi's methodology,

> *"Idiographic analysis may form part of the process of analysis but the eventual aim to explicate – eidetically – the phenomenon as a whole regardless of the individuals concerned. Idiographic details are thus discarded or generalised"* (p. 9).

In contrast to Giorgi's view of phenomenology, IPA has an idiographic focus as a core feature of the approach. The commitment to an idiographic ideal creates a microscopic lens for viewing each case, emphasising an approach that lends psychological meanings through a detailed study of individual experience (Eatough and Smith 2008). The hermeneutic approach employed through IPA provides opportunities for interpretation and reflection through relevant theoretical perspectives, which allow these findings to be linked to the psychological literature (Smith et al. 2009). As Smith et al. (2009) note, a study using descriptive phenomenology would typically result in a third-person account,

> "*A synthesised summary statement outlining the general structure for the phenomenon under question*" (p. 200).

In contrast, the results of an IPA approach would be in the form of commentary and,

> "*Usually takes the form of a more idiographic interpretation, interwoven with extracts from the participants' accounts*" (Smith et al. 2009, p. 201).

3.5.4 Critiquing interpretative phenomenological analysis

Phenomenology was first developed in a time of turmoil. Husserl saw the need to bring warring factions of thought together. His vision was to create a new scientific method that would heal the rift between the natural and the empirical sciences, the relativists with the realists. However, the traditions of warring factions continued within phenomenology traditions where opposing philosophies of this new methodology emerged. Heidegger (1927) criticised Husserl's application of bracketing and introduced a hermeneutic approach to phenomenology, extending Husserl's approach to include interpretation. Similarly, Smith extended the hermeneutic approach to become a double-hermeneutic and idiographic approach naming this new methodology IPA (Smith et al. 2009). In doing so, Smith was brought into the opposing factions of phenomenological philosophers. The sections below briefly describe, analyse, and evaluate four issues that have been proposed as conundrums for the philosophy and methods of IPA.

The first problem concerning IPA, raised by van Manen (2017), questions IPA's relationship with phenomenology. van Manen contends that IPA, with its idiographic pillar, is more concerned with psychological sense-making or reflection of the individual than an understanding of phenomena. van Manen's claims

extend to critique the psychological underpinning of IPA in providing the deeper problem that *'emotional psychological themes'* of an IPA study,

> "*Tend to be assessed as superficial and shallow from a phenomenological perspective*" (van Manen 2017, p. 778).

Smith's (2018) rebuttal states that van Manen's critique is based on pre-reflective studies. In contrast, Smith (2018) states, it is just as crucial for phenomenology to concern itself with the pre-reflective as the reflective, as both are an essential part of the broader contribution to academic fields of study. Continuing this exchange, Smith warned against any single person having authority over what constitutes phenomenology (Smith 2018). Zahavi (2020), A third voice to enter the critique, shared some of the same concerns of IPA as van Manen and then picks up a similar concern within the research work of van Manen himself. While these researchers have concerns over the application of phenomenology in some research studies, the common thread between these researchers is their alignment on the focus of phenomenology to be on '*the thing'* itself. Thus, in this thesis, it is vital to maintain that interprofessional practice is the '*thing*'. The phenomenon of interest is the participants sharing the experience of being in a healthcare setting with an interprofessional practice approach.

The next problem to be posited concerning IPA is the question of its attitude to interpretation and hermeneutics, with the question, "*How can it be both?"* (Shinebourne 2011, p. 17). Hermeneutics has been declared as the art of understanding (Schleiermacher 1991). Phenomenology may be explicitly descriptive, or hermeneutic, so long as it is an understanding of the lived experience (e.g. Giorgi 2009; Smith et al. 2009; van Manen 2014). Hermeneutic is

also a term which means interpretative. So, the use of the term interpretative in IPA has a double meaning, it is interpretive in that it is hermeneutic (understanding the meaning of a phenomenon), and it is interpretative in that it is idiographic (understanding the meaning for individuals within a phenomenon). Therefore, the emphasis is on the research question and its implications. Researchers may seek to uncover the felt experience (interpretative) or the meaning of the experience (hermeneutic). For this thesis, the terms within IPA are used as interpretative as in idiographic, to assess the individual's experience of interprofessional practice, and hermeneutic as in searching for the meaning of the experience of being in a phenomenon of interprofessional practice as an approach within a healthcare setting.

The third conundrum is that IPA has been questioned concerning its intentionality to be critical or empathetic (Finlay 2013). This differentiation comes from the dual understanding of hermeneutics as a meaning of recollection (empathic engagement) and suspicion (critical engagement). Smith (2004) posits that IPA can maintain both critical and empathic modes of interpretation within a single study to provide a complete understanding of the participant's experience. IPA may ask critical questions of the participants, and it may also seek to understand what it is like from the participant's point of view (empathy) (Eatough and Smith 2008). Larkin et al. (2006) suggest that both forms of analysis provide an entry to the hermeneutic circle, allowing a more enriched interpretation. For this thesis, the data collection was already conducted prior to the IPA methodology being applied so a critical or empathic view was not considered when designing the research questions. However, in undertaking an analysis of the interviews careful consideration was given to the way the question was posed when assessing the

participants response, and notes were made during the stages of the analysis on any anomalies to the question and response structure so that they could be taken into consideration at later stages of the analysis.

The final quandary explored regarding IPA is the approach used to allow entities to announce themselves within the phenomena (Galbusera and Fellin 2014). Using both an idiographic and hermeneutic approach may seem contradictory, leading to the question, how does IPA prepare for this quandary? Phenomenology means *'to show itself'*, to bring to the light of day, to allow to shine, something that was not in the light before the investigation (van Manen 1984). As a researcher undertaking an IPA, my interpretation of this dilemma has come to recognise that an entity (individual or thing) can show itself in many ways; some are soft and difficult to find, while some yell from the rooftops and bring all their friends to shout and scream to get attention. Heidegger (1962) critiqued such entities as some may lead to truth, but some may show themselves as something that they are not. A hermeneutic approach would seek to understand entities within the phenomenon, while an idiographic approach would seek to understand entities from each participant one by one.

So, how does an IPA researcher determine which entities need to come forward in the investigation? Smith (2011) provided a way through this quandary by exploring entities as gems. A gem may sit in a passage that identifies itself early in the interpretation but is not entirely clear. Going around the hermeneutic circle polishes these gems so that the researcher can see their real value as their meaning becomes comprehendable. The hermeneutic circle continually moves between the parts and the whole, like fine sandpaper rubbing back an archeologic

discovery of a gem to discover how it fits in a crown. Smith (2011) continues with this analogy finding gems, suggesting that while the types of gems just described may initially elude the researcher, others may be shining when they are first encountered. Still, other gems may be initially secretive, with little happening on the surface. The researcher needs to pay more attention to find these. It may come from a slip of the tongue in an otherwise non-suggestive interview passage or the way someone infers something that was not there. Smith suggests that each gem helps the researcher understand a meaning that is part of the phenomenon (Smith 2011). In this thesis, these gems were carefully sought (within the text), watched (along the interpretative journey) and polished (in rounds of hermeneutic analysis) to reveal secrets about the experience of being interprofessional that were not understood before.

3.6 Researcher's view on working within this paradigm

While learning to work within an IPA methodological mindset, I was enlightened by the words of Smith et al. (2009) in describing the pillars of IPA with each one having a specific purpose within the analysis, and in the way Smith described the gems that could be found amongst the text (Smith 2011). These words guided me in exploring and interpreting meanings that went deeper than descriptions alone could illuminate. My creative side also resonated with the philosophy of Gadamer (1997; 2007). Gadamer saw the truth as more than just a linguistic concept. He encompassed truth as an aesthetic that fits into a frame of the scientific theory (Gadamer 1989). For Gadamer, the truth could be seen in a work of art, experienced through dance or heard within a musical composition. In this way, the truth held within an artistic production may be experienced through aesthetic

consciousness, while the oeuvre's experience represents the expressive power of its truth. Many researchers have found that using art as a way for individuals to express their experience has opened new doors in helping them to view meaning. One of the important notes on the use of IPA in this study, is the dependency this approach has on the use of language, as words are the only door to interpreting meaning from the participants interviews (apart from some non-verbal cues that were noted along with the interviews). In particular there was a limitation on interpreting the words of the clients through the use of an interpreter, which takes away from the clarity of understanding the direct words of the clients.

However, within the interplay of an IPA approach, I have found that research itself can be interpreted as an art form, in alignment with Gadamer's philosophy, produced by words instead of paint or dance. Accordingly, the research artist's purpose is to draw the observer (reader) into the phenomenon as it was for those that lived the experience. The words in the participants interviews form the colours of paints and materials of the canvas. The research artist, through interpretation, brings these elements together. The purpose is to invite the reader into the lived world of the subjects at moments that had meaning in the phenomena. The methods used have similar steps to those of works of art, bringing the materials together, understanding what the materials are, knowing how they might work together. Then the researcher, as an artist, brings something from within themselves to paint the picture of the rese as a thesis. The result is the researcher's impression of how the participants felt collectively in the moments that showcased their truth.

The reader also brings themselves to the interpretation of the research. They do this through their preconceptions of the subject and their expectations of what they will see and feel when the story is revealed. The reader may be reassured by the work that it fits their worldview or surprised that it does not. Nevertheless, the research artist cannot control the outcome. They must let it reveal itself, announce itself, through the use of their careful words and delicate framing. The research artist cannot know who will read their work. They can only put their true self into the composition and try to honour the time of the people who gave of themselves to be part of the research by painting an authentic representation of their shared experience.

3.7 Summary of this chapter

This chapter explores the ontology, epistemology and worldview of the researcher in determining the correct fit for the research paradigm for this study. Three research paradigms were explored in the way that they may address the subject matter of interprofessional practice. However, only one of these paradigms (constructivist) would allow the exploration of the lived experience of the participants in the phenomena. The methodology was then determined to be qualitative and phenomenological. Different fields of phenomenological enquiry were explored. The methodology created by Smith et al. (2009), interpretative phenomenological analysis (IPA), was determined to be the one that would allow the lived experience to come to light.

The IPA methodology was discussed in terms of its historicity, alignments and critiques. IPA has three pillars, phenomenology, hermeneutics, and idiography. Each pillar was assessed for its application to the research question. In addition,

the four criteria provided by Yardley (2000) to assess validity and rigour in qualitative studies were examined in detail. These criteria were aligned with the IPA approach and how the researcher ensured each criterion was attended to within the research. Four conundrums of using IPA as a methodology were addressed with the questions raised and answered concerning this study. Finally, the researcher took time to reflect on a personal view of how IPA was applied in the research to paint an authentic picture of the phenomenon of interprofessional practice in a way that aims to enlighten readers.

Chapter Four: Methods

This chapter provides a detailed account of how the study was conducted, from the study context and setting, by selecting the participants, recruiting clients, data collection, and data analysis. Samples of analysis are noted and provided in the Appendices to illustrate the methods used. Strategies used within the research to validate the rigour and trustworthiness of the methods are explained using examples.

4.1 Introduction

To increase awareness and understanding of interprofessional practice, an in-depth exploration of practitioners and clients' experience of being part of an interprofessional practice approach was the focus of this thesis. The research questions were designed to explore this experience through how the participants thought about their interactions and how they affected them. Interpretative Phenomenological Analysis (IPA) was the methodological approach used to

analyse and interpret interview data. A detailed description of this study content follows.

4.2 The context

This research was conducted within a clinical program named Branching Out, which utilised an interprofessional practice approach to healthcare. The clinical program was initiated by two practitioners of the cohealth community health centre in Melbourne, Australia, and funded by an internal grant from cohealth. Given my interest in interprofessional practice, I was invited to meet with the originating practitioners by cohealth management. After meeting with the lead practitioner for the Branching Out program, it was identified that the clinical program contained elements of an interprofessional practice approach to service delivery. However, the practitioners were not familiar with interprofessional terminology or implementing an effective interprofessional practice approach. Hence, it was determined that the program would benefit from further alignment to an interprofessional practice approach. This alignment included training the practitioners in the key elements that differentiate an interprofessional approach from multi-disciplinary teamwork. The practitioners utilised other clinical interventions as part of the Branching Out program, but they are outside the remit of this thesis. The selection of practitioners for the clinical program and clients who would be part of the program was based on clinical need and conducted solely by the cohealth community health centre practitioners. My involvement was to provide the interprofessional practice conceptual framework and participate in the training for the practitioners in interprofessional practice. Once the program

was set up, my focus shifted to researching the experience and conducting interviews over time.

4.2.1 The service

This study was conducted at cohealth community health centre located in Melbourne, Australia. cohealth is a not-for-profit community health organisation that provides vital local health and support services in more than 30 locations across Melbourne's CBD, northern and western suburbs. These services include medical, dental, allied health, mental health, aged care and counselling services, and many specialist health services. All members of the community are able to access these services.

People of refugee and asylum seeker background are among the more sizable client groups for cohealth, and the centre maintains a positive, welcoming approach to this population. For example, in 2013, a large banner was erected across their entrance reading, *'we welcome refugees and asylum seekers'* (Appendix A). Similar messages were placed on walls around the waiting area of the centre. Although most people of refugee and asylum seeker background cannot read English (Grillo 2005, Procter et al. 2013), the signs were an indication of welcoming and meant to encourage those in the community to recommend and support people of refugee and asylum seeker background to seek help if they needed to. Signs and pamphlets in the local multicultural community's languages were also available within the centre.

4.2.3 The Branching Out program

'Branching Out' is the name of an innovative program for clients of refugee and asylum seeker background diagnosed with chronic pain. The program was developed by a team of practitioners at cohealth and is designed to help these clients take charge of their pain and begin to branch out and do more of the things in life that they want to do (cohealth, 2014).

A care model that includes practitioners from two or more professions was proposed as a driver to provide integrated support with these clients. The program was developed with an interprofessional practice approach that included an initial joint therapeutic session in which a joint assessment was undertaken to achieve integrated care. In this initial session, the practitioners worked together with the client to develop a narrative of the client's unique experience and the influence of their particular context on their individual health needs. Other processes that supported an interprofessional practice approach included: team meetings, joint sessions held in between single profession-specific sessions, and additional joint therapeutic sessions for ongoing clinical interventions. The key to the interprofessional approach was integrated, holistic care compared to the fragmented service they would have experienced prior to this program's inception. At a minimum, physiotherapy and counselling support were provided by using an interprofessional approach. Other professions within the community health were accessible to clients as needed.

There are no guidelines in the interprofessional practice literature on implementing joint therapeutic sessions with practitioners of multiple professions. Therefore, the practitioners engaged in the sessions based on the critical elements of teamwork

recognised by Reeves (2012) in his framework for interprofessional practice, as outlined in Chapter Two. These elements are shared team identity, clarity of roles, the interdependence between team members, integration of tasks, and shared responsibility.

In addition, the design of Branching Out was informed by a previous study of the program ActivePlus that was also conducted at cohealth (O'Sullivan et al. 2018). This study, which included the researcher, utilised a similar approach with practitioners from multiple disciplines working together with the client in joint therapeutic sessions that enabled them to share different areas of knowledge and develop a deep bond with the client. The Active Plus program's key learnings were incorporated into the Branching Out program and then modified to the client group's needs. For example, the in-depth collaborative assessment conducted at the initial session of the ActivePlus program was a mechanism that was also included in the Branching Out program.

The aim of the Branching Out program was to strengthen the quality of life for a specific vulnerable client group by engaging with the client in an integrated manner. In this way, the program brought together psychological, physical, and social interventions and provided self-management tools. The program supported the client to look at new opportunities in life and build on their existing resources (i.e. strength-based techniques). In designing the program, the practitioners acknowledged the impact of torture, trauma and settlement experiences on the client's health and wellbeing and incorporated psychological safety messaging (e.g. ensuring the client understood the sessions would be confidential, and they could stop at any time) and culturally safe practices where possible. The

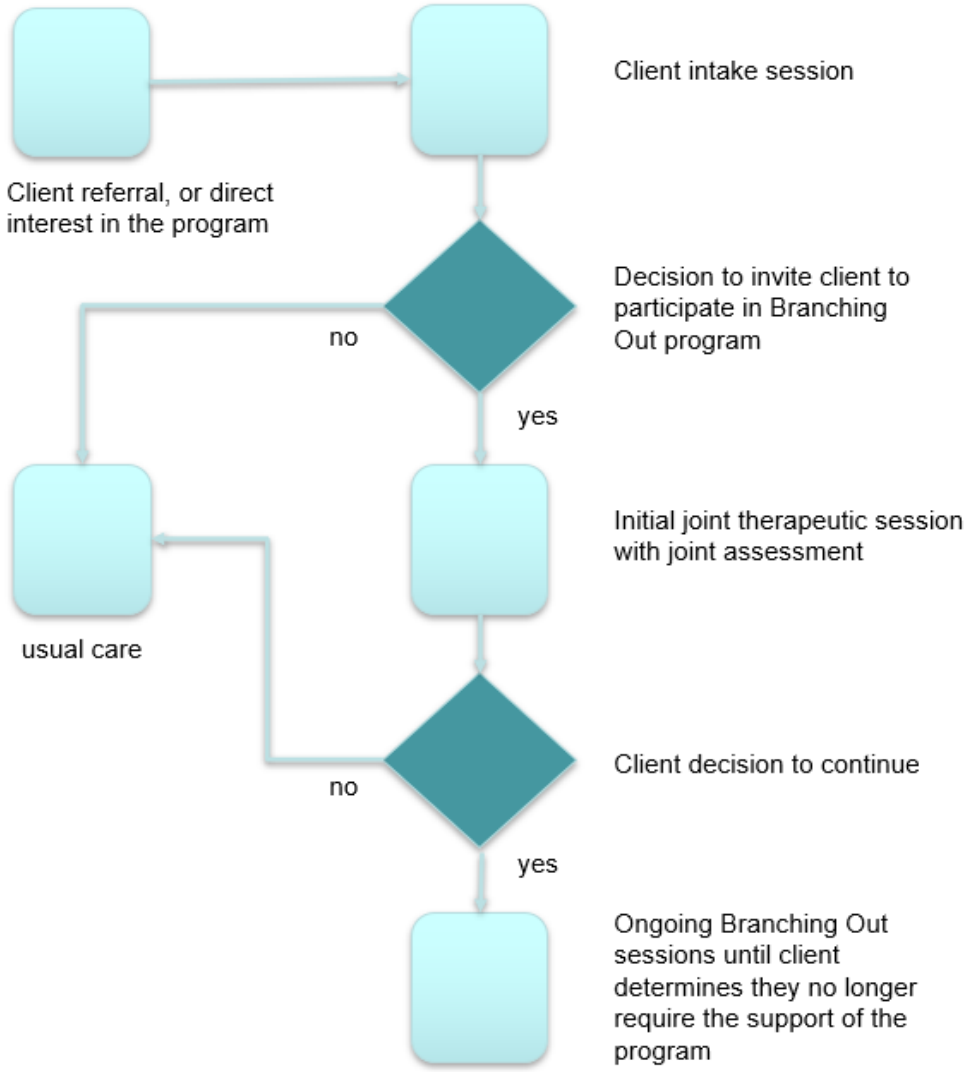
interprofessional practice approach was a keystone of this intervention. It aimed to build trust and understanding between the client and the respective health practitioners, thus enabling client strength building to occur.

The practitioners at cohealth were trained and experienced working with clients from refugee and asylum seeker backgrounds. The initial team engaged in a one-day interprofessional workshop consisting of presentations, interactive group work and an interprofessional discussion. The workshop was led by a practitioner trained in interprofessional practice from Victoria University.

4.2.5 The framework of clinical sessions

The Branching Out program was structured as an interprofessional team approach from the initial intake through all sessions of the program. The initial intake session was conducted by one practitioner over the phone with the client, and then details of this intake were discussed at an interprofessional team meeting for a recommendation from the team to invite the client to participate in the program. A flowchart depicting the intake for the Branching Out program is provided in Figure 4.1.

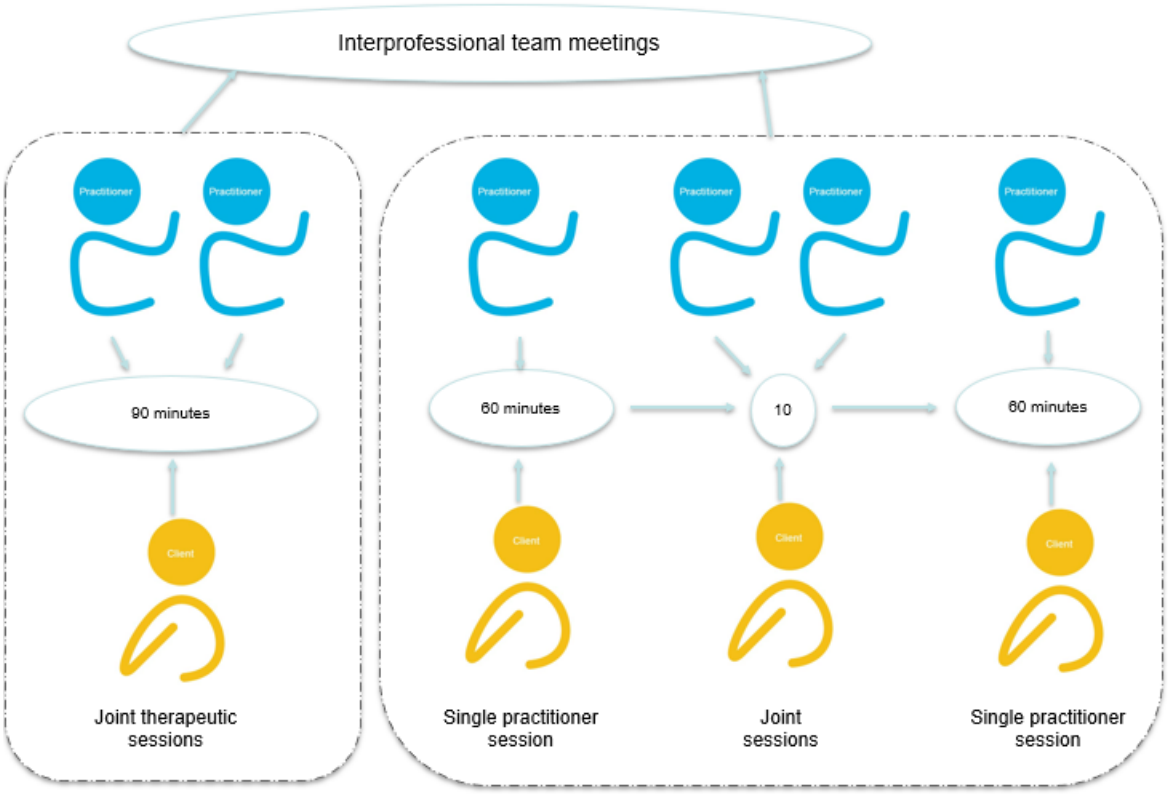
Figure 4.1 Branching Out program intake process



The first session of the program was a joint therapeutic session with two practitioners (usually a physiotherapist and counsellor) meeting with the client in a joint assessment session. At the completion of this initial joint therapeutic session the client then decided if they would prefer to continue with the interprofessional care pathway or with a usual care pathway (generally with just one practitioner). The program framework included interprofessional team meetings in which practitioners discussed the ongoing care plan for individual clients. The

interprofessional care pathway developed for the Branching Out program is shown in Figure 4.2.

Figure 4.2 Interprofessional session approach



4.2.6 Politics of the region affecting this study

When this study began, Australia was in a state of political turmoil concerning arrival and detention policies for refugees. These controversial policies caused much debate in the media, leading to distrust and suspicion by the public. As a result, people of refugee and asylum seeker background in the community have often felt persecuted for their presence, despite having a legal right to access services.

The act of seeking healthcare requires a level of trust as one can be vulnerable during care and reveal information that may be important to the care, but the client may not want others to know this information outside of the care setting (Mechanic 1998; Denecke et al. 2015). This socio-political context results in barriers for people of refugee and asylum seeker background seeking services such as healthcare, as they may not feel welcome or trust those providing services. Understanding these socio-political issues was vital for developing the Branching Out program.

4.3 The Study

The participants in the research were the practitioners and clients of the Branching Out program. This research uses a multi-perspectival design incorporating a directly related group (Larkin, Shaw and Flowers 2018). In a multi-perspectival design, the two subgroups, in this case, the practitioners who took part in the Branching Out program and the clients of this program, were immersed in the same experience. However, they were likely to have different experiences of their participation in the program. Unlike many other studies which focused on practitioners and clients (for example, Borg Xuereb, Shaw and Lane 2016; Larkin, Clifton and De Visser 2009; Wawrziczny et al. 2016), this study is not considered a dyad study as the practitioners and clients did not have a direct one-to-one connection. Within the Branching Out program, clients were assigned to an initial joint therapeutic session (two practitioners from different professions). However, if they decided to continue within the interprofessional practice pathway, the practitioners who met with the client in later sessions may not have been the same

ones as in the initial joint therapeutic session. The following sections expand on these two groups of participants.

4.3.1 Participants

This section details the two groups of participants in this study, providing their demographics and recruitment into the study.

4.3.1.1 Practitioners

The Branching Out team consisted of four counsellors, two physiotherapists, two *'Living Well'* workers (both from occupational therapy), and a massage therapist (who was also a nurse). All practitioners (n=9) who delivered the Branching Out program were advised of this research study when they joined the program. They were invited to participate in the research (Appendix C) and were asked to provide written confirmation of their consent (Appendix D). All practitioners involved in the Branching Out program agreed to participate in the study.

4.3.1.2 Clients

For this thesis, a client was considered to be of refugee or asylum seeker background if the client identified as such. Over the course of the program, arrival populations were from Iran, Afghanistan, Iraq, Burma, and Sri Lanka. Less frequently were populations from the Horn of Africa and Tibet.

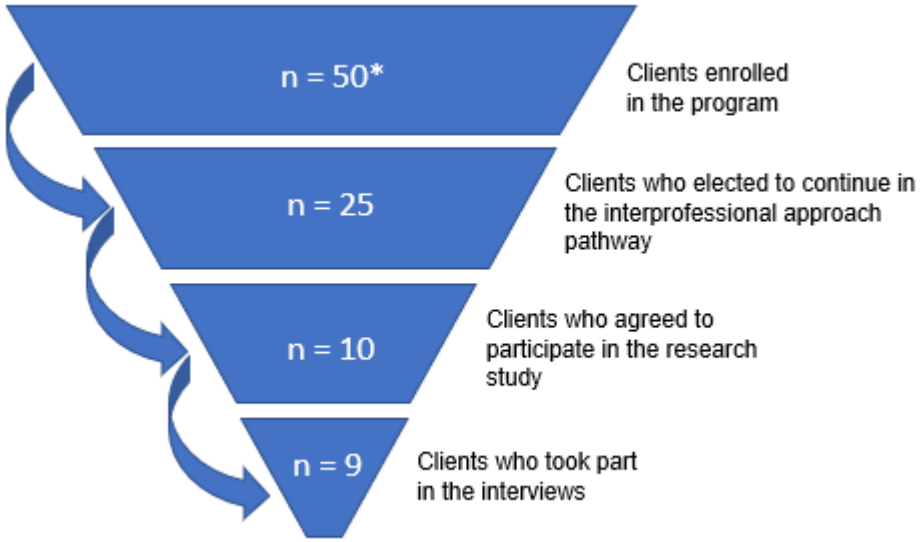
Clients of cohealth currently living in the community as asylum seekers are likely to be on a Bridging Visa-E. The restrictions of this visa currently make this group particularly vulnerable in our society. Dependent on their arrival date, they cannot

work and are generally eligible for the equivalent of 89% of the New Start[2] allowance with limited case support. They are also generally in a situation of insecurity, as their permanent protection visa has not been granted. Under current restrictions, they are not able to be reunited with their family. Under a Bridging Visa-E or with refugee status, a client would be able to access all services of the cohealth community health centre.

The client participant pool for this research was all clients referred to the Branching Out program (Appendix B) who subsequently enrolled in the program after an intake interview. The client cohort was referred to the program by local physicians, and clients could make direct contact with the centre to enrol. Practitioners who were members of the Branching Out program undertook the intake interviews with clients to determine their suitability for the clinical program. The inclusion and exclusion criteria for the client intake was part of the clinical program and, therefore not included in this thesis. The client participant sample was a subset of this larger pool, as shown in Figure 4.3.

[2] New Start is the basic job-seeker allowance provided by the Australian government

Figure 4.3 Clients participating in the study



*Client numbers at the time of the final client interview.

The average length of time in the program for clients was 12 months, with a range of six to 24 months. When a client was nearing the end of their time in the program, the practitioners invited them to participate in the research study. Invitations were given to all clients completing the program, whether they were self-graduating (successful completion) or withdrawing from the program, to ensure all client experiences could be captured.

Upon agreement, clients were provided with information and consent forms (Appendix E), read to them by the practitioner or by an interpreter if required. Upon consent, the lead practitioner notified the researcher, providing the clients first name, contact details and preference for an interpreter.

Fifteen clients (who continued in the interprofessional pathway) did not consent to participate in the research. The practitioners noted some cultural influences. For example, no Karen population clients (an ethnolinguistic group of Sino-Tibetan language-speaking peoples) consented to interview despite being one of the most

significant cultural populations represented in the Branching Out program. One client (not Karen) who consented to be interviewed was not able to be contacted.

4.3.2 Data Collection

The data collected in this research was primarily the text of the interviews held with the practitioner's and clients, along with any notes made during and after the interviews and information collected in the researcher's journals. The data collection methods are described in detail in this section.

4.3.2.1 Practitioner interviews

The researcher developed the interview questions (Appendix F) to attempt to capture practitioner's thoughts of the experience of being part of the interprofessional practice approach and how they felt other practitioners and the clients were experiencing being part of this approach in the care setting. The rationale for the questions was based on a critical case study methodology and so were aimed at allowing the participant to tell the story of their experience with the researcher. The questions were shared with the lead practitioner of the Branching Out program, and language refined. The questions were all open-ended in nature. The questions were provided to the Ethics Approval Board for certification for use in this research study.

Three rounds of interviews were conducted with the practitioners between 2014 and 2020. However, not all practitioners took part in each round (see Table 4.2). The initial interviews with four practitioners took place seven months after the launch of the Branching Out program. The second round of interviews with eight practitioners took place approximately twelve months later (20 months from the

program's launch). This round of interviews coincided with the first round of client interviews, as the initial clients were close to completing their time in the program. Also, at the time of this second round of interviews, new practitioners had joined the program since the initial round, so this was their first interview. Second interviews were conducted with the practitioners whenever possible to allow the practitioners to provide additional insight into their experience of being part of the interprofessional practice team. The final interview with only the lead practitioner of the Branching Out program was undertaken in 2020 (other practitioners were no longer available for additional interviews). This final interview was undertaken prior to completing the analysis of the practitioner's interviews as it was noted that this practitioners experience of the program was not represented in the findings in a meaningful way to the amount of time she had been part of the program.

The interview rounds, dates and participants are provided in Table 4.1.

Table 4.1 Practitioners interview schedule

Profession	*Interview rounds*		
	July 2014	*August 2015*	*October 2020*
Physiotherapist (lead practitioner)	✓		✓
Counsellor	✓	✓	
Counsellor	✓	✓	
Counsellor	✓	✓	
Physiotherapist		✓	
Exercise Physiologist		✓	
Counsellor		✓	
Nurse, Remedial massage therapist		✓	
Registered nurse		✓	

For each round of interviews, practitioners were emailed to arrange a suitable day and time for the interview. All interviews were conducted in a private, quiet space, for example, in a meeting room or a personal office on the premises at cohealth. The interview duration was approximately an hour, with a range of 45 to 90 minutes. Notes were made during and after the interview of non-verbal cues to facilitate later interpretation.

Each interview started with a brief chat (for example, about local news) to build rapport with the participant. Following this, the researcher read a definition of interprofessional practice (AIPPEN 2012) to establish a shared understanding of the term. The interview questions were then asked in the same order with each participant. However, if a participant wanted to expand on a particular issue this was explored in a semi-structured manner prior to the next structured question being asked. A semi-structured format was adopted with probe questions to gain a deeper understanding of the participant's experience.

Interviews were audio-recorded with the practitioner's consent. A commercial transcription service provided a full transcription of the recording. Member checking was undertaken, with all interview transcripts returned to the practitioners for verification of the content. The practitioners were informed they could make additions or deletions to the transcripts; however, no transcripts were altered. All practitioners provided written approval for the transcripts to be used in this research study.

4.3.2.2 Client interviews

The researcher developed the interview questions in the same manner as the practitioner questions, with the questions aimed to allow the clients to provide as much information as possible about their experience in the Branching Out program. The set of questions (Appendix G) was shared with the lead practitioner and refined to ensure familiar language for the clients. The questions were all open-ended in nature and deemed easy to understand. However, notice was taken of the need to read the questions to an interpreter who would then need to translate it to the client. For this reason, the wording in the questions was a

simple as possible. The questions were provided to the Ethics Approval Board for certification for use in this research.

On being informed of the consent of a client for the study, the researcher was informed of the client's first name, contact details, and the details of their preferences for an interpreter. The researcher contacted the client by phone, utilised a phone interpreter where appropriate, introduced herself and the research study and invited the client to attend the interview at the cohealth centre. All client interviews were conducted in a private meeting room at cohealth to ensure a familiar environment and with the interpreter (as needed). On the day of the interview, the reception staff at the centre were advised the clients would be attending and would ask for the researcher by name. The reception staff were provided with the researcher's contact details to advise when the interpreter and client arrived. Before the interview, the researcher met with the interpreter to explain the research study and role expectations during the interview. The researcher and interpreter then greeted the client together and escorted the client to the interview room.

Once in the room, consent was requested from the client to audio record the interview. The client was advised that they could stop the interview at any time and did not need to answer questions that made them feel uncomfortable. The focus of the study was the Branching Out program's interprofessional approach. As a definition of interprofessional practice would not be meaningful to the clients, the researcher instead informed the clients that the interview was being conducted to evaluate this new care model. The clients were informed that their feedback would help shape the program for future clients.

Seven of nine interviews were conducted utilising an interpreter, with two of these using a phone interpreter. The remaining had the interpreter present in the room with the client and the researcher. The average duration of the interviews was 45 minutes, with a range of 35 to 50 minutes. Notes were made during and after the interview of verbal and non-verbal cues to facilitate later interpretation. For example, while using an interpreter, one client reached out and touched the researcher while providing their response in a gesture to ensure the researcher understood the answer. At times, interpreters translated the client's words in several ways to aid in translation. On two occasions, the interpreter explained the cultural meaning of some phrases used by the client following the interview. All client interviews were transcribed verbatim by an independent transcription service, and the researcher checked these transcriptions manually for accuracy while listening to a recording of the interview. No alterations were made to the transcripts by the researcher.

After the interview, the client was provided with a voucher valued at $30 to offset the attending costs. The Ethics Committee approved the voucher. This voucher was not advertised to the client before the interview to not bias attendance or the client's attitude in responding to questions concerning their healthcare service (Bonevski et al. 2014).

4.3.3 Ethical considerations

Ethical approval for this research was gained from the Victoria University high-risk human ethics board on behalf of Victoria University and the cohealth community health centre on 28th May 2014. The ethics approval number is HRE14-132. The

information for practitioners and clients, along with consent forms and interview questions are provided in the Appendices.

This study was deemed a high-risk human intervention because the research interviews yield client evaluations of service and peer evaluation of service provision by staff, both of which could be prejudicial if made public.

The participating clients were considered a vulnerable group in ethical terms because they were from refugee and asylum seeker status, have physical health problems, cultural differences, socioeconomic issues, and many did not speak English as a first language and were isolated. However, all clients were referred to the program from within cohealth, an organisation familiar with clients' treatment and care with this background. The service accepted referrals for adults aged over 18 years, with normal cognitive ability, and born overseas. As the research study focused on the interprofessional approach in this care setting rather than clinical treatment, the client's vulnerability was minimised. Interpreters were provided whenever needed to address language difficulties. Due to the broad range of participants' languages and varying literacy levels in the country of origin, all documents were in plain English and explained to the clients using an interpreter.

Some emotional discomfort may have been felt from participating in an interview as part of this research program due to the nature of the clinical population (i.e., people of refugee and asylum seeker background experiencing chronic pain). This emotional discomfort was minimised by ensuring the interview questions were only directed towards the client's interprofessional practice experience within the Branching Out program. The interview was not designed to explore the

clients' experience with trauma; however, while reflecting on the service experience, some trauma experiences were raised that had been addressed during the treatment program. Participants who agreed to participate in the interview were informed that they could stop the interview at any time. A protocol was developed where if any client became distressed during the interview, the interview would be stopped, and further counselling would be offered. However, this protocol was not needed during the study.

The data collected in this study included anonymous and non-sensitive interview data that posed no foreseeable risks or discomfort to participants. The audio files were only used for analysis and were not accessible outside the research team. The transcripts and data analysis documents were unidentifiable. All client and clinician information were de-identified using pseudonyms to minimise the exposure of identifiable information. No personalised or identifying information relating to participants is included in this thesis.

Once the interview session was completed, the researcher uploaded the audio files to a secure, password-protected site at the university. Physical data, including the interview transcript, researcher's reflexive journals, and the participants signed consent forms, were stored in a secured locker in the researcher's office and maintained for seven years. At the end of this period, all physical data will be securely destroyed, and digital files removed from the university's servers.

4.4 Data Analysis

4.4.1 Analysis of practitioner's interviews

As outlined in Chapter Three, IPA was chosen as the method of analysis for this study. The IPA follows four stages to arrive at a fusion of interpretation between the participant and the researcher, as recommended by Smith et al. (2009). These four stages are flexible guidelines adapted by researchers to align with their research objectives. The four stages are summarised in Table 4.2. with descriptions of each stage, how it was completed, and any changes undertaken in this thesis. Examples are provided in the Appendices from the research findings (Appendix H) to allow the reader to comprehend the researcher's method.

Table 4.2 Summary of IPA stages and critical priorities (adapted from Pietkiewicz and Smith 2014).

Stage	Title	Key priorities
1	Multiple reading and making notes	Data engagement
2	Transforming notes into emergent themes	a. Creating researcher notes
		b. Combining both participant and researcher notes to emergent themes
		c. Grouping emergent themes into themes and sub-themes
3	Clustering themes	Understanding of connections and relationships between participants
4	Writing up	Interpretation and presentation

A discussion of these four stages is provided below.

4.4.2 Stage one: Multiple reading and making notes

Stage one involved immersion in the information provided by the participant. This information includes the audio recording, interview transcription, notes recorded during the interview, and any observations or comments journaled during the research (Pietkiewicz and Smith 2014). To fully immerse in each participant's account, the analyse of each participant's interview was undertaken on separate days. If two or more interviews had been undertaken with the same participant,

each interview was allocated a particular day for reflection and then set aside before the following interview was analysed. In this way, I was able to focus on just one interview at a time for all participants.

The review began by re-listening to the audio of the interview and taking my thoughts back in time to this. The interview's feelings, thoughts, and atmosphere were recalled, as were any non-verbal communications present on the day (as per journal reports or through remembering the interview). The transcript was formatted in a word document for this activity into three columns with continuous line numbering, with the transcript text in the middle column, as recommended by Smith et al. (2009). In the left column, notes were made while listening to the audio, reading the transcript, and reflecting on the participant's words. This column mainly contained the exact words as the participant so that a reflection on the keywords used by the participant as possible. Then in the right-hand column, notes were made providing initial thoughts on the interpretation of the words. This process continued until there was comprehensive documentation of the transcript, representing the participant's and the researcher's perspectives in the columns on either side of the transcript. Any components of the text identified as potential gems were underlined and notated with the letter '*G*',

> "*The gem is the relatively rare utterance that is especially resonant and offers potent analytic leverage to a study*" (Smith 2011, p. 6).

An example of this process is provided in Appendix H.

4.4.3 Stage two: Transforming notes into emergent themes

The second stage of analysis required the transformation of the information gathered from stage one into emergent themes. The focus of this stage was to look for meaning in the emergent themes and consider if the participant's words had an intention that was not fully articulated or hidden in the way it was said (Pietkiewicz and Smith 2014). Smith et al. (2009) provide suggestions for six ways to help investigators identify patterns between emergent themes: abstraction, subsumption, polarisation, contextualisation, numeration, and function. Each of these strategies was tried and somewhat helpful but not sufficient. These strategies are outlined in Table 4.3.

Table 4.3: Strategies applied to identify emergent themes

Strategy	Application of the strategy
Abstraction	Identifying patterns between emergent themes, clustering like with like, and identifying a new name for the cluster (Smith et al. 2009)
Subsumption	Emergent themes are clustered into a super-ordinant status, bringing together a series of related themes (Smith et al. 2009)
Polarisation	Identification of patterns of difference instead of similarity, providing an oppositional relationship between emerging themes (Smith et al. 2009)
Contextualisation	Highlighting constellations of emergent themes which relate to particular narrative moments, or key life events (Smith et al. 2009)
Numeration	Noting the frequency with which a theme is supported which may be an indicator to the importance of the theme (Smith et al. 2009)
Function	Providing a focus on the function of the language use alongside the meaning and thoughts of a participant (Smith et al. 2009)

This stage of analysis is the component that was the most difficult. The practitioners' meaning was not able to be interpreted clearly, and earlier preconceptions were pulling back the focus of the analysis to being a categorisation of mechanisms and activities.

Meeting with an IPA methodology coach, support was provided to apply the process of IPA. One practitioner transcript was worked through in detail with the IPA coach providing modelling of the IPA process, which was very helpful. However, a final breakthrough occurred with the idea to use creative writing skills to help tease out meaning. A docufiction account was created (a fictional account based on the integration of facts from real encounters) of a day in the life of two of the practitioners as they interacted in a care setting similar to the study program (Appendix I). To create this docufiction required a connection with what the practitioners must have felt to conceptualise dialogue and action between them. This process helped me understand how to interpret the participant's feelings and enter their phenomenological world. A recent paper by Smith (2018) also helped guide the finding of meaning-making on both participant and researcher. Smith's paper elaborates on what is meant by IPA's concern with the search for meaning and led to a deeper understanding of the action of meaning-making by the participants. Sessions then continued with the IPA methodology coach until a clear understanding of the analysis process was achieved and followed with confidence. All practitioner transcripts were analysed to the end of this first stage before the second stage was started.

The second stage of the process was undertaken across all emergent themes in three parts. The first part (a) required reflection on the three columns of

information from stage one to create a combined statement that conveyed the text's intent. This new statement was typed into an excel spreadsheet. The line numbering from stage one was included with the statement to make it easy to go back to the text when needed quickly. An excel spreadsheet was used for this stage of analysis because of my familiarity with the benefits this program can bring to aligning and comparing large amounts of data. Parts of the original text marked as '*G*' (gems) were maintained in full in this stage and included in emergent theme statements where applicable. At the end of this stage, the emergent themes remained in chronological order as they appeared in the transcript.

For the second part of this stage (b), a full copy of the emergent theme statements was made and added in the same spreadsheet below the first copy. Each line of the new copy was grouped, with a subheading representing the grouping of statements. The grouping was done by taking the first statement and comparing and contrasting it to each other statement. This process continued until all comparisons were exhausted. Items relating to the same or similar topic were grouped as a theme.

The third part of this stage (c) required another copy of the data, this time from the second (b), to be placed below the spreadsheet's original. In this stage, my knowledge of the emergent themes and reflections on the participants' intent was used to create statements of subthemes that captured multiple statements from stage two. In this step, the hermeneutic circle came into play. The analysis frequently moved back and forth between the parts and the whole of the text to interpret the participants' experiences and understand the data. This process continued until all emergent themes were encapsulated in these statements; that

is, no new themes were identified. This process was repeated for each transcript. Again, parts of the original text marked as a gem were maintained in full and included with the emergent theme statements. Line numbering from the original transcript was maintained at all times so that verification could be made later of the origins of an interpretation. An example of this process is provided in Appendix H.

4.4.4 Stage three: Clustering themes

This stage of analysis required clustering themes across participants, which involved developing a master spreadsheet of themes from each interview to determine how they related to each other visually. Using an excel spreadsheet was beneficial here. It provided an efficient method to reorganise and relabel themes and subthemes while maintaining each subtheme's hereditary subtheme back to individual cases for clarification. However, at a certain point in the analysis, the relationship of subthemes with individual cases need to be removed so that the IPA process could progress. At this point, the emergent themes developed into super-ordinate themes across the study population and therefore became meaningful to the experience of being in the phenomenon. Analysis and interpretation were complete once commonality was found among the themes. The themes were then reduced into final themes (four practitioner themes) that captured the essence of interprofessional practice experience across participants.

4.4.5 Stage four: Reporting of practitioner findings

The IPA findings undertaken with the practitioner's interview transcripts are reported in Chapter Five, including quotes from participants for each of the themes. Chapter Five was written immediately following the analysis of practitioner interviews and before analysing the client findings. In this way, the practitioner findings were completed by writing the chapter and then put to one side as the analysis of the client interviews was undertaken.

4.4.6 Analysis of client interviews

While the analysis of the client interviews followed the same four stages as the practitioner interviews, the findings were not as deep or rich as those of the practitioners due to the interviews' limited nature. That is, the client interviews were shorter in duration, and most had an interpreter present which required time for the interpreter to relay information between the researcher and the participant. Furthermore, unlike the practitioners, all clients participated in only one interview.

Stages one to three were carried out on a single day for each client. At stage one of the analysis, the researcher became re-immersed in the client data by listening to the audio files and reading the transcripts and journal notes one client at a time. Notes were made in the three-column format in a word document and then transferred to an excel spreadsheet where the data was examined for emergent themes. Each of the client interviews was reduced to a small number of emergent themes before entering stage four which sought to cluster themes across client cases. Three super-ordinate themes were identified across client cases.

4.4.7 Reporting of the client findings

The findings of the client analysis are reported in Chapter Six. The major themes and subthemes are reported in the same way as the practitioner findings were reported in Chapter Five.

4.6 Validation of research findings

The ability to confidently assess the validity and quality of qualitative research is paramount to the integrity of the study. Guidelines to assist this assessment were produced by Elliott, Fischer, and Rennie (1999) and refined by Yardley (2000), which present a broad-ranging criterion applicable to all qualitative studies. The four critical dimensions of these guidelines are particularly relevant to an IPA approach. These dimensions are *'sensitivity to context'*, *'commitment and rigour'*, *'transparency and coherence'*, and *'impact and importance'*. Each of these components is discussed below concerning this study utilising an IPA approach.

Yardley's (2000) first criteria are sensitivity to the context in which the study is undertaken. In this study, the context begins with the choice of methods and the rationale for their adoption, which are provided in this chapter and within the description of the methods utilised in this study described in Chapter Four. This thesis will demonstrate sensitivity in the participant's material to support arguments being made by providing the participants with a voice in the study (providing extracts from their interviews) allowing the reader to check the researcher's interpretations (Smith et al. 2009).

A question has been raised on qualifying research into interprofessional practice, that, in itself, interprofessional practice may not strictly be a phenomenon. Although not explicitly stated in the literature, questions of whether interprofessional practice may not be a phenomenon are based on the lack of theory used to describe it in an explicit manner (Freeth et al. 2008), where theory is an explanation or interpretation of a set of phenomena. Another dissenting factor is that no shared definition of interprofessional practice has been achieved. Also, the contingent approach inherent in interprofessional practice (the specific approach of each interprofessional team based on the needs of the specific client cohort) means that each experience of working together in an interprofessional team may vary depending on the client's needs. However, interprofessional practice does have unique properties compared to other forms of teamwork, such as its values-based practice and collaborative nature. These properties allow being interprofessional to be distilled from practitioners' broad experience in other forms of teamwork. Thus, allowing being interprofessional to be captured as a phenomenon in this thesis.

Yardley's (2000) sensitivity to context criteria also includes the requirement that the researcher remains sensitive to the participant's individual experiences and understanding of their predicament during the research engagement. In this thesis, the engagement with each participant (practitioners and clients of the Branching Out program) was undertaken with guidance from the lead clinical practitioner for the program. The lead practitioner and the researcher discussed the approach and objectives for the interviews at the planning stage of the research program. The interview questions were pre-approved by the Ethics Committee of Victoria University and were adhered to as closely as possible. The

interviews were undertaken with the participant and the researcher in the session and an interpreter where required. One exception to this was with a client where it was decided that a clinical psychologist should be on hand in case the participant became distressed during the interview. The clinical psychologist acknowledged their presence with the client at the start of the interview and then remained external to the room, ready to be called upon. Fortunately, the clinical psychologist was not required during the interview, and the client happily proceeded with the interview to its natural conclusion.

The use of commercial interpreters for seven of the nine client interviews is noted in relation to the context and sensitivity of this study. Where a client requested an interpreter be available, this was put in place, ensuring that the interpreter matched the client's choice for language, dialect, gender, and region of origin. An interpreter was present in the room wherever possible for the client interviews, as opposed to a phone interpreter (two client interviews required a phone interpreter as an interpreter of the client's choice was not available in Victoria and interstate interpreters were used). The face-to-face meeting was considered beneficial for the client in that they could see and hear the interpreter enhancing the communication.

The use of an interpreter offers an additional layer to the double hermeneutic of the study for these clients, which could be interpreted as a triple hermeneutic. However, it is also noted that during the Branching Out program, these clients would have an interpreter present while attending clinical sessions. Nevertheless, for these seven clients, the commercial interpreter's conversion of language for

the client, practitioners and researcher needed to be considered during the analysis of the data.

The second criteria in Yardley's (2000) assessment validity and quality of research are commitment and rigour. Using an IPA approach, the assessment of commitment is demonstrated through the research approach methods, while rigour refers to the thoroughness and completeness of data collection and analysis. In this study, nine practitioners and nine clients were interviewed following their participation in the Branching Out program. Every practitioner who took part in the Branching Out program agreed to be interviewed. One client who agreed to be interviewed was not included, as the contact details for the client had expired before an interview could be conducted. While each interview was attended to with the same meticulous detail in an idiographic approach, not all participants were chosen to represent each of the themes in the overall body of findings. However, each of their voices is included in this study as an example of an interpretation or individual experience.

Yardley's (2000) third criterion, transparency, and coherence, refers to the clarity of the research process and the description of the steps taken. These steps are enunciated in detail in Chapter Four of this thesis. Coherence refers to the clarity of the presentation of the argument in the discussion. Smith et al. (2009) note that a coherent approach may include,

> "*Finding ways to include ambiguities and contradictions inherent in the data in a coherent way*" (p 56).

According to Yardley (2000),

> *"Coherence also describes the 'fit' between the research question and the philosophical perspective adopted, and the method of investigation and analysis undertaken"* (p. 222).

For this thesis, the alignment of the work to IPA demonstrates the commitment of the researcher to ensure the right approach for the investigation of the research question.

The fourth criterion from Yardley's (2000) assessment of validity and quality are impact and importance. The engagement of the reader, or "*Resonating with readers*" (Elliot et al. 1999, p. 224) is fundamental in assessing the validity of the research for,

> *"The real validity lies in whether it tells the reader something interesting, important or useful"* (Smith et al. 2009, p. 183).

Yardley (2000) argues that impact and importance are the critical criteria by which research must be judged. For this thesis, the criteria of *'being interesting'* is determined within the research question by addressing the conundrum, *'is interprofessional practice a phenomenon?*' This query has not been addressed previously in the literature and will be necessary for future phenomenological studies. The criterion of '*importance*' is addressed within the research question by exploring the notion, *'how do practitioners make sense of the beneficence of an interprofessional practice approach?*' This study raises issues on how practitioners judge this ethical concept and how the contingent nature of interprofessional practice will affect future studies where this question is raised. The criterion of '*usefulness'* is addressed in this study by examining the benefits of an interprofessional practice approach that includes joint therapeutic sessions in a

care setting that is part of general process of care in a community health centre as opposed to a pilot program. The findings of this study may be applicable to other community health centres who are considering an approach that includes joint therapeutic care.

4.6.1 Trustworthiness and rigour

> "*If I have seen a little further, it is by standing on the shoulders of giants.*" (Isaac Newton, 1675).

The ability to *'see a little further'*, made famous by Sir Isaac Newton's quote, only becomes a possibility if you are sure the giants you choose make a steady base from which to stand. The giants in research are the base of those who have come before. To be useful as this base to interpret new findings, benchmarks are applied to research as a validation to determine the suitability of others' findings to be incorporated into new work (Revicki et al. 2007).

Trustworthiness and rigour are terms applied to how we work to meet the criteria of the validity, credibility, and believability of our research and to meet expected standards set by leaders in our academic field, our participants, and our readers (Rossman and Rallis 2011). Several validation measures of trustworthiness and rigour have been provided in this thesis to allow others to assess the usefulness of the findings provided in this report for use in further studies.

Guba and Lincoln (1994) proposed a set of terms to ensure trustworthiness and rigour across qualitative research fields. The terms credibility, confirmability, dependability, and transferability are now standard practice in qualitative research

to establish confidence in the data (Connelly 2016). Table 4.3 provides these four criteria for trustworthiness and the techniques used in this study that align with each criterion. In the sections below, each of these criteria is expanded, and the techniques are explained.

Table 4.3 Summary of how criteria for quality were met

Criteria	Technique
Credibility	Peer debriefing, member checks, engagement in the dissemination of topic
Confirmability	Audit trail, integration, journaling
Dependability	Auditor, expert validation, worked example of analysis provided
Transferability	Thick description, journaling

4.6.1 Credibility

The credibility criteria are satisfied within this study by using the mechanisms for peer debriefing, member checks, and engagement in disseminating the topic.

Peer debriefing was undertaken with the lead practitioner for the Branching Out program. Together, the lead practitioner and I planned the research approach, ensuring that the interview schedules were part of the Branching Out program's planned processes. I met with the lead practitioner on several occasions to discuss and agree on any issues concerning the participant's interview schedule.

The lead practitioner was a named person of responsibility in the ethics application for the research study. Care was taken at each stage to minimise any bias introduced by the lead practitioner's dual roles as both a research peer and participant in the study.

The lead practitioner was provided with a draft copy of this thesis and invited to provide feedback on the analysis and major themes and subthemes to ensure critical components were represented in a manner that would minimise the identification of participants. Feedback was considered carefully again to minimise the introduction of bias to the overall findings.

Member checks were undertaken with the practitioners who participated in the study. These checks included specific times at the start of each one-on-one interview with the practitioners. These interviews began with a short introduction and discussion on how they felt about being part of the research study and a recount of the definition of interprofessional practice and if this definition resonated with them. This discussion was included as the first section of the interview and included when the interview transcript was returned to the participants to verify accuracy. The practitioners were asked, *'Does this interview transcript reflect your words during the interview?'* and were prompted to edit the transcript if they were not satisfied with the wording, wished to exclude any part of the transcript, or wished to include any further detail.

4.6.2 Confirmability

Throughout this thesis, three techniques were used to confirm the research findings: an audit trail, journaling, and integration of the findings.

The audit trail is a transparent description of the interpretation of the data taken from the start of a research project to developing and reporting findings (Lincoln and Guba 1985). Examples of each step of interpretation are provided in the Appendices, and references are made at each step within the report's methods.

Journaling started with the first thoughts on how the study may progress and has continued at each stage of the data collection and interpretation daily, weekly or monthly, culminating in a reflexive journal of the study. Throughout this study, I met with my principal supervisor and members of the supervisory team monthly. For each of these meetings, I prepared a report of the research's progress and discussed all pertinent items with my supervisors. As feedback was provided or changes made on the study's direction, these were noted and discussed again at the next meeting. Journaling activity was most prominent immediately following interviews with participants, after peer review sessions, and before and after presentations at conference events. The journaling activity and the reflection this activity provided on the changes being made to the study as it progressed allowed me to be cognisant of my changes in awareness of the issues raised in the study and how my preconceptions had influenced early design decisions. For example, the major change in the approach for the analysis of this study was undertaken following reflection on the study progression and an awareness of my bias towards trying to find a way to quantify the results.

Reflexive journaling was undertaken weekly during the IPA stage of this study under the expert coach's mentoring. This journaling activity helped me understand my progress in comprehending the IPA methodology and appreciate how I entered new phases in exploring findings using the hermeneutic circle.

Multiple data sources (other relevant theses, journal articles, methodology books, methodology coach, supervisors) were used within this investigation to enhance understanding of the findings (Lincoln and Guba 1985). This technique has allowed an account of the findings that is rich, robust, comprehensive, and well-developed. The integration of findings between the practitioner and client emergent themes has been provided in part two of Chapter Seven.

4.6.3 Dependability

Two techniques were used consistently throughout this research study to allow the reader to have confidence in the research findings' dependability: an expert coach and worked examples of all analysis steps.

An expert IPA methodology coach guided the use of IPA, ensuring rigour in the process. My PhD supervisors supported the engagement of this expert coach, and Victoria University provided approval. The expert coach has considerable experience in using, supervising, and examining IPA projects, coaching this methodology since 2004, and is the country coordinator for IPA for Australia. Through online discussions and email correspondence, the expert coach provided clarity to the appropriate use of IPA, supported the back alignment of the thesis, and helped narrow the focus of the thesis. The expert coach modelled the IPA process and used the outcomes of one of the transcripts as a rigour check. The expert coach reviewed each chapter of this thesis and provided comments to provide a deeper understanding of an IPA approach.

A worked example of each stage of the IPA is provided in the appendices. Reference is made to these worked examples where appropriate within the text.

4.6.4 Transferability

This research study's transferability determines if the findings can be transferred to other contexts or settings with other respondents. A thick description and journaling have been used as sources of validation of transferability throughout this thesis.

A thick description is achieved by describing the phenomenon of interest in sufficient detail. Others can evaluate the extent to which the findings are transferable to other times, settings, situations, and participants (Lincoln and Guba 1985). Since it is the reader's or future researcher's responsibility to decide how this study's findings may be applied to other settings, this thesis has provided detailed information about the phenomenon to assist in this decision. At each stage of the report, as much information as possible is provided so that the reader may develop a vivid picture of the research events. These details have included: location settings, details about the participants, attitudes and feelings of the participants, reactions observed that were not captured on the audio recordings, and feelings of the researcher.

As provided in section 4.6.2.2, reflexive journaling was undertaken during the IPA stage of this study under mentoring of the expert methodology coach.

4.6.5 Dissemination of findings

Early findings were presented as oral presentations (20 minutes duration) at two international conferences aligned to interprofessional practice: The New Zealand Interprofessional Practice conference (NZIPP) held at Auckland University in

August 2016, and The All Together Better Health (ATBHIIX) conference held at Oxford University in the United Kingdom in November 2016. For both conferences, an abstract of 300 words was submitted to the scientific committee (Appendix J), and as a result, the researcher was invited to provide a presentation. Presentation and attendance at these conferences allowed a broad discussion of the topic amongst peers, which was reflected upon during the course of this study.

In addition, networking and discussion amongst peers in relation to the early findings of this study occurred during attendance at the following international conferences: All Together Better Health (ATBHIX), held at Auckland University in September 2018; and the Self Determination Theory Conference, held in Amsterdam in May 2019.

Chapter Five: Practitioner analysis

This chapter begins with personal reflexivity and then provides the findings of the practitioner's experience working within a program with an interprofessional practice approach to healthcare. The illumination of the practitioner's interview findings follows an interpretative phenomenological analysis (IPA).

Four major themes emerged from the IPA of the practitioner's experience, each with different aspects revealed through interconnected subthemes. These major themes are 'Coping with a new approach', 'Where do I fit within the team', 'Consolidating Understanding' and 'Finding the balance for the client's benefit'.

The analysis provided in this chapter with across case interpretation follows the standard format of reporting on investigating findings when utilising IPA, as outlined by Smith et al. (2009).

"I.. dipped into Husserl for the first time. Sartre had told me all he knew about Husserl: now he presented me with the German text of 'Lecons sur la conscience interne du temps', which I managed to read without too much difficulty. Every time we met we would discuss various passages in it. The novelty and richness of phenomenology filled me with enthusiasm; I felt I had never come so close to the real truth" Simone de Beauvoir (Beauvoir 1965, p. 231/201)

Just as Simone de Beauvoir proclaimed in this passage from her memoir, finding truth through phenomenology brought me to a place where I felt the reality of the participants' experience in this program was able to be illuminated. I came to understand that the genuineness in how the practitioners revealed their day-to-day experience of being part of an interprofessional approach demanded an appreciation of their struggles as well as their achievements. The results of the IPA revealed in this chapter reflects this awareness.

The practitioners background information is provided in Table 5.1. A pseudonym represents each practitioner to protect their anonymity. When assigning pseudonyms, an effort was made to choose names that reflected the culture, ethnonational background, and original inflection of gender of each participant. (Allen and Wiles 2016).

Table 5.1 Practitioners background information

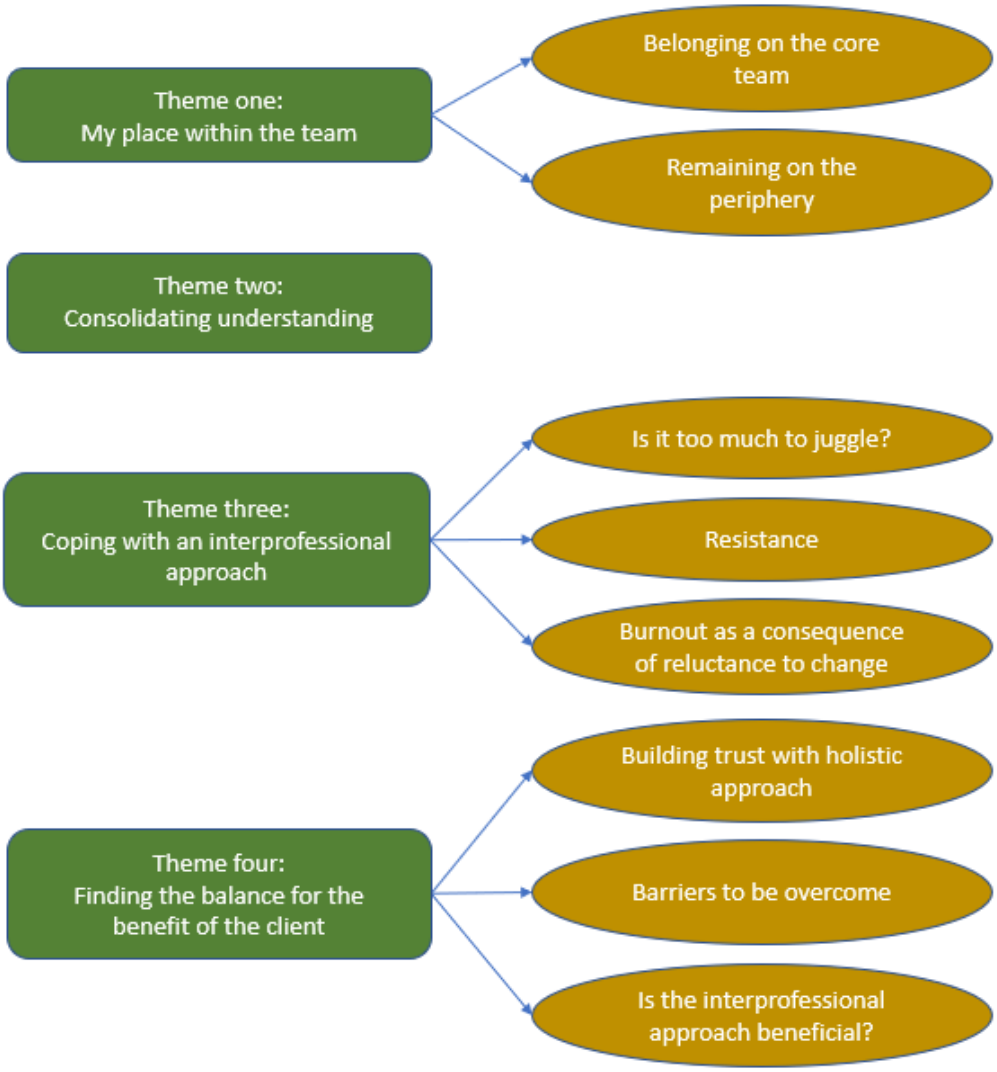
Participant Pseudonym	*Profession*	*Stage of career*	*First interview*	*Second interview*
Amelia	*Physiotherapist*	*Early-career**	*August 2015*	
Violet	*Exercise Physiologist*	*Early-career*	*August 2015*	
Ava	*Physiotherapist*	*Mid-career***	*July 2014*	*October 2020*
Charlotte	*Counsellor*	*Mid-career*	*July 2014*	*August 2015*
Oliver	*Counsellor*	*Mid-career*	*August 2015*	
Liam	*Counsellor*	*Mid-career*	*July 2014*	*August 2015*
Chloe	*Counsellor*	*Mid-career*	*July 2014*	*August 2015*
Aurora	*Nurse, Remedial massage therapist*	*Mid-career*	*August 2015*	
Hazel	*Registered nurse*	*Mid-career*	*August 2015*	

*Early-career = less than five years' experience; **Mid-career = more than five years' experience; ***Late-career = more than 15 years' experience

Professions contributing to the Branching Out program included counselling, physiotherapy, remedial massage, exercise physiology, and nursing. Practitioners ranged from early career to mid-career in their experience within their profession.

The four major themes and their subthemes that emerged from the IPA are shown in Figure 5.1.

Figure 5.1 Practitioner major themes and subthemes



All practitioners contributed views to each of the emerging themes. In this way, the major themes and subthemes came together to make up the practitioners'

whole experience. Themes are ordered to allow the practitioner's increased immersion in the interprofessional practice approach to be illuminated. Each major theme and corresponding subthemes are explored in the following sections, supported by relevant quotations derived from the practitioner's interview transcripts.

5.1 Theme one: My place within the team

The first major theme emerged from the practitioner's accounts of belonging and their understanding of their place within the team. Practitioners reflected on how proud they were of working alongside others within a community health practice and the quality of people the practice attracts. For example, Liam provided an insight into his decision to work in community health,

> *"Personalities do make a big difference (…). You can have people in the office where they can be great workers in their work, but they can be abrupt or abrasive or something like that. They can be hard to approach, they can be tough, and that could be because they are very stressed or something, so it spills out in that way. But, it can just be their mannerism or their style, and community health doesn't tend to attract personalities like that, which is really lovely. So, the style of person who gets attracted to something like community health - because it's underpaid, and you have got to be flexible anyway because it's always changing. So, it does tend to have a spirit about the place that is different from, say, a hospital under hugely different pressures (…). So, the values probably permeate through" (Liam, counsellor, interview one, lines 237-252)*

Liam felt that the practitioners who work in community health made sacrifices, influencing the personality types attracted to working in this setting. In calling upon *'a spirit'*, Liam felt the values that set the practitioners apart from other work environments shape how those already in community health feel about how they belong in these care settings.

Over and above this context of belonging to a community health setting, Oliver showcased his feelings of belonging to the Branching Out team,

> *"I think we have become a closer-knit kind of team – a bit like a mini team. I guess, in the middle of all of this we are all parts of other teams and stuff. But, at least I feel I have stronger attachments to say [the practitioners in the Branching Out team]" (Oliver, counsellor, interview one, lines 122-125)*

Oliver's use of the terms '*closer-knit team'* and *'mini-team'* provide a clear picture of the practitioners having a separate identity from those around them. The practitioners found the interprofessional team unique, *'In the middle of all this*', as in the middle of all the other activities around them in the community health centre, they had developed strong attachments to each other.

However, Oliver also discusses some team members being on the periphery because they do not regularly attend team meetings and are therefore not part of the '*core*' team. He elaborates on his feelings for these other team members,

> *"There's a couple of people that have been brought into it, but I think they are committed, but they are kind of on, it feels like it's a bit more of the periphery of it. And so, they don't usually come to the team meetings because they are busy. So, I think there's a bit of a kind of, say, a 'corer'*

group within the team that come regularly to the meetings and, there are probably others that are a bit more peripheral at the moment and we all hopefully, we will all merge more into it, but there are so many demands here it's hard." (Oliver, counsellor, interview one, lines 239-249)

Oliver felt that some practitioners are *'brought into'* the program. Given practitioners volunteered to participate in the program (as a component of their usual practice), Oliver's words suggest that the group has accepted their membership. This description likens the group to a club where members are vetted before being accepted. These newer practitioners were described as '*committed*' but do not attend team meetings due to their pressure to balance these new activities with their existing workload. Oliver acknowledged that everyone on the team felt busy and overloaded, but he does not accept this as the reason for not attending. Instead, he felt these practitioners had not made the team a priority as he had. Liam suggested that the practitioners finding excuses not to attend interprofessional activities need to *'adapt and grow'* into the team, suggesting that those immersed in the team had changed. A potential implication of this suggestion from Liam may be that some team members may not have gained the tacit knowledge of working in an interprofessional approach (e.g., the importance of attending team meetings) as others have done.

Oliver went a step further when he denoted those members who put in the time and effort to attend interprofessional activities as belonging to the *'core group'*, which sets them apart from those on the periphery. Other practitioners did not mention this demarcation of a core group and a peripheral group in the same direct terms. However, other practitioners shared moments where they felt a belonging to the team and moments of doubt in this sense of belonging. Two

subthemes were revealed within this theme of exploring where practitioners felt they fit within the team, which are now explored in more depth.

5.1.1 Belonging on the core team

The first subtheme illuminates how the Branching Out team was created and the bonds that kept them together. This subtheme included shared values, respect, a learning culture, inclusion, emotional connection, purpose, vision, point of difference, and calling others on the journey.

The groundwork for building a healthcare team that can practice in an interprofessional, client-centered manner must start within the organisation's leadership and framework to provide the support required for the teamwork approach. Within this study, the practitioners have moral philosophies that align with the cohealth organisation, as stated by Ava,

> *"I think again that thing about already being in an organisation that has some values connected to it is helpful – so everyone is coming from the perspective of client-centered care. And, then I think it's just having the time and also facilitated conversations that are respectful of others. Which to this point haven't really needed to be facilitated because everyone has been very respectful and they are all approaching this from a learning perspective" (Ava, physiotherapist, interview one, lines 51-56)*

Ava describes cohealth as an organisation driven by values, so staff bring these values to join the interprofessional team. She believes the practitioners in this study act from a respect for each other and treat their experience within the team

from a learning perspective. This value of respect within a culture of learning provided a potent foundation for creating a sense of belonging, as seen in the comments by two practitioners,

> *"So, as a Nurse, but just as a professional who feels like, you know, you have a duty of care, and that's the bottom line for people that work in community health, often you do extend ourselves because we are just seeing that people are just not getting appropriate access or fair treatment (…) I think that's what a lot of the principles of community health are, and cohealth, and I suppose I probably feel very strongly about social justice so for me it's just a given really" (Hazel, registered nurse, interview one, lines 251-254)*

> *"We are lucky here, we have a pretty amazing group of professionals working here" (Chloe, counsellor, interview one, lines 25-26)*

The alignment of cohealths' values with an interprofessional practice approach was important for the practitioners' success in adapting to this new way of working.

Another foundational element in creating a sense of belonging was that team members felt empowered by a culture of inclusion. An emotional connection to the organisation, the team's purpose, and the other team members were essential for building this inclusion culture. For example, in the quote below, Ava describes the process of forming the team as '*bringing people along*' on a journey that highlighted both the connection she felt to the program and the responsibility she felt for the team members,

" You know you're bringing people along on that journey and you have called people on that journey." (Ava, physiotherapist, interview two, lines 199-200)

Ava's further remark of having '*called people on that journey*' reinforced this responsibility and her sense of trust that adopting an interprofessional approach would be worth the while of others who joined. This trust was essential for others starting their journey of belonging to the team.

Ava's feeling of trust and sense of a calling of new members joining the team as time progressed contrasted with the comments made by Oliver (cited previously). He felt team members that did not put in the effort to attend team meetings chose to sit on the periphery rather than join the in-group. Oliver remains guarded in his interactions with the team members who sit on the periphery. At the same time, Ava is less guarded of these members (is not concerned these members may influence others in the team) and more supportive of the team as a whole to work through any conflicts. These differences in Oliver and Ava's attitudes towards others may reflect their position within the team. Ava is one of the two practitioners who spent a long time negotiating with cohealth management to establish the program. Thus, she had a high level of responsibility for its interprofessional approach. Oliver joined the program a short time later, which allows him to be more critical. He does not carry this same responsibility for establishing the program in the eyes of cohealth management. However, he is still passionate about ensuring all members follow the ethos of the interprofessional approach.

The practitioners' emotional connection to working within the community healthcare setting was also apparent in their work within the interprofessional team. Practitioners expressed their enjoyment in working within an interprofessional approach, as noted by Ava and Liam,

> *"Certainly, in the experience of starting to meet new clients, it's been fantastic. It's been such a great way to support clients from different practice dimensions and then coming together for the development of the client outcomes, it's been great to have the opportunity to work with new clients in this way." (Ava, physiotherapist, interview one, lines 24-27)*

> *"We have had shared assessments, so the two practitioners from different disciplines doing the assessment together and consulting with each other afterwards and ... collaborating around the treatment plan and what clients need and presenting it to the client as a team approach to their healthcare. So, I have enjoyed that, it has been quite good." (Liam, counsellor, interview two, lines 8-12)*

Ava and Liam expressed how much they enjoyed the program, which was intertwined with their feelings of being immersed in supporting clients. However, not all practitioners felt this sense of joy or immersion.

When establishing the interprofessional approach processes for the Branching Out program, the teamwork culture was guided by the practitioners' vision of how they would work together, their goals and frameworks. Without this shared vision, a team can become fragmented, causing tension between team members with different expectations. Charlotte, as one of the initial members of the Branching Out team, discussed how this vision was developed,

"It was really crucial for us trying to make a point, so okay, so this [interprofessional practice] will actually differ from multidisciplinary teams; and ones about process and the other is about structure, you know. It was so important for us to advocate for what we wanted …it [the vision] really provided a framework of what it could be about" (Charlotte, counsellor, interview two, lines 172-176)

Charlotte described how crucial it was that the team decided to be different from other programs delivered by multidisciplinary rather than interprofessional teams. The team's vision and the processes and activities that would guide the interprofessional approach were documented in the framework developed for the program. This framework helped set the culture, which brought about harmony and encouraged team members to develop a sense of belonging. As one of the founding practitioners and driven by a desire to create something new for the clients, Charlotte stressed that she needed to advocate for the client's needs with cohealth management to establish the program. The interprofessional practice approach alignment with client-centered care provided a foundation to launch Charlotte's new program vision.

For some team members, the development of this vision and new processes were the essential part of the program. Liam recalled an old maxim that reminded him of the critical components,

"There is an old phrase about project work. This type of project work in a sense, [the Branching Out program] *is what everyone looks at, as this is the shiny, glittery thing we have, this project. But in fact, the process is the real project of how this evolves over time. So, the process is the show in a way.*

That's the phrase that comes to mind for me" (Liam, counsellor, interview one, lines 372-376)

Liam highlights that he felt the day-to-day working out of collaborating in an interprofessional manner was crucial for the program. Through this teamwork process, the practitioners created something new, held in tacit knowledge within the team. The value Liam placed on this collaboration provided another sense of having something that belonged to the team that is not available to those not part of the team. The next subtheme explores the experience of practitioners who did not have the same sense of belonging.

5.1.*2* Remaining on the periphery

This subtheme explores practitioners' attitudes of why some team members were on the periphery. This perspective was captured in Oliver's earlier quote when he introduced the terms '*core*' team and '*peripheral*' team members. Despite the collaborative philosophy and principles of the interprofessional approach, some team members did not feel able to participate in the interprofessional activities on a day-to-day basis. Barriers to being part of the core team included: not having enough time to attend interprofessional activities, not being immersed in the approach, not having trust in co-workers, the need for flexibility in attendance at team meetings, and not having a clear understanding of the roles and responsibilities of all members of the team.

Exploring the first of these barriers, Liam explains the interest and curiosity he had about joining the program team, but also the anxiety he felt coming into the program several months after the launch,

"I think there is probably a bit of trepidation and in terms of potential workload because it's actually quite complex. On the one hand, Branching Out has its own intake system in a way. So, from a counselling perspective, it means that we are all worried we might be getting a new client every second week or something. Which might not sound like much, but you might be seeing that client for 10 or 12 weeks, which may be say ten sessions, but that doesn't mean every single week. It often will be spread over 12 or 15 weeks. So, there's a cumulative impact, so there was some anxiety about, "Oh gosh!, What have we committed to?" ... and it is going to work ..., but it actually isn't working out that way, which is partly a relief. So, just to talk about feelings so that - there's just a real interest and curiosity. And it's just really, I wasn't involved from the very beginning, I got brought in several months later, so in a sense, the current structure had already been decided on for this current model." (Liam, counsellor, interview one, lines 36-41)

Liam is hesitant about how the interprofessional practice approach will work because he was not part of the team that determined the framework. He describes a situation where he perceives he has a potentially unmanageable workload, followed by a sense of relief that it did not work out that way. He felt excused from responsibility if the current framework for the interprofessional approach is not sustainable.

Charlotte, one of the team's initial members, also reflects on new members coming into the program. Charlotte is concerned that these new members are

needed to help with the workload, but they have not been trained or included in conversations regarding the vision and goals of the program,

> *"It's yet to be seen to what extent they have to be as immersed as we have been or is it possible to do this in a flexible enough way that, you know, you don't overwhelm a few people ...because there has been some sense of a conversation that has evolved, and why do we even have to think about the program? Why is it relevant? So, being part of that conversation all along gives you a bit of perspective about the work. People have come in at this point. We don't know if it will be a problem or not. So, that's I suppose, the suggestion would be about being flexible, but also being clear about what's important about the program so that you can communicate that easily to other people" (Charlotte, counsellor, interview one, lines 102-111)*

Charlotte wonders if new team members can come into the program and be involved in some interprofessional activities, such as the initial joint therapeutic sessions, without being involved in others, such as team meetings but still be part of the team. However, Liam has already brought our attention to the importance of practitioners' being a part of each interprofessional activity. Through this participation, they create the tacit knowledge of interprofessional practice as they learn from each other.

Another problem arose for newcomers to the program regarding how much time they felt they needed to commit to the program. For example, Chloe explained her dilemma in attending a session with the client that ran for 90 minutes when a typical consultation session would be 30-40 minutes,

"So, in terms of, you know its 90 minutes of my time, and I am happy to be a part of the project. But I guess, then 90 minutes and then writing up the assessment, so it's like an initial session but generally when the clients come for initial sessions they want counselling, so that there is a follow up contact with either myself or another counsellor. And then there is also the stress that if the [Branching Out] client wants counselling, then you have to fit them into your caseload. And, that can be a stress knowing that. So, most recently when I did the [Branching Out] assessment I was thinking, 'Oh my God', I hope she doesn't want counselling, because I am booked out four weeks in advance." (Chloe, counsellor, interview two, lines 39-47)

Chloe participates in the initial joint therapeutic sessions with new clients despite feeling she does not have the time to allocate to a program of clinical sessions if the client needs ongoing care. Like Liam, Chloe felt a lack of trust that those who set up the program did not consider her needs as a therapist. Chloe had these dissenting thoughts before meeting with the clients and was thinking them to herself during the initial joint therapeutic sessions. It would be difficult for Chloe to be building trust with the client at the same time as feeling she hopes the client does not wish to continue with care. In this way, Chloe allows the burden of developing trust with the client to rest with her co-practitioner while she has these thoughts. Chloe's comments at this moment are at odds with the interprofessional practice approach and the cohealth community health centre's underlying values. The burden Chloe felt the interprofessional practice approach created resulted in her remaining on the team's periphery. As such, she was unable to benefit from the supportive aspects of a team approach.

On joining the Branching Out program, the practitioners' roles and responsibilities and the interprofessional approach were articulated to all members. However, Ava reflects on how some of the practitioners may not have felt as connected as others,

> *"People are feeling more peripheral than they feel included, but they understand the work and, I guess, what's required of them in their role and what their expectations would be around the model. Some of the challenges are, we were scheduling and identifying* [client needs]. *And I guess people embedded, or on the periphery, was sort of a result of that unfolding kind of story." (Ava, physiotherapist, interview two, lines 195-213)*

Ava suggests the program is a mixed picture of service availability (which practitioners from which professions are available to meet with the client) and program flexibility (how much practitioners could be flexible with scheduling joint appointments) to meet the clients' needs. In additional sections of her interview, Ava also reflected on the practitioner's availability and how much time their relevant Managers approved to contribute to the Branching Out program. These variable parameters provide an insight into the many ways a practitioner who is otherwise considered to be involved or committed to the program may still feel they are on the periphery if their profession or time availability does not align with the team vision. While Ava's insights reflect how a practitioner's profession may not be as in demand as other professions for some clients, it does not explain why these practitioners are not engaged with the program's interprofessional activities.

However, as a counsellor, Chloe should feel part of the core team as one of the modalities required in almost every client care team. She had put aside a

consistent timeslot in her calendar for others to make client bookings for joint therapeutic sessions for her attendance. In contrast, Chloe portrays a resentment for being expected to put time into client sessions booked in these allocated timeslots. Moreover, Chloe has not made an allowance for the client follow-up time in her caseload or feels she cannot do so due to commitments already made to generalist counselling. Chloe's reflections seem to suggest that although she wanted to be part of the program team, her motivation may not have been aligned to an interprofessional practice approach. Interestingly, Chloe continued with her role on the interprofessional team despite her feelings of frustration at the role's perceived demands.

5.2 Theme two: Consolidating understanding

The practitioners' described a sense of empowerment to learn, which initially came from their supportive environment within the cohealth community healthcare organisation. The practitioners showcased this new learning setting by listening and sharing their professional knowledge with others. Ava shared how this learning setting took shape,

> *"I think I felt from where I sat in the program that, you know, everyone I was working with was really open to different perspectives so people would be listened to or so forth. But [I] cannot think of a particular instance of conflict that sort of resonated with me, or real differing opinion where you couldn't go anywhere. I think it's really normal to have a different take on an assessment and have a conversation around that, but as long as you feel that your central values and way of working is aligned, then that's [what] you can work through." (Ava, physiotherapist, interview two, lines 371-381)*

Ava described the practitioners as listening to each other with respect, even when they may have had a difference of opinion. This perspective comes from Ava's vantage points as both an originating member of the team and a practitioner who took part in most joint therapeutic sessions.

As outlined above, several other practitioners raised issues around the program's processes, the additional time the program takes in their workload, and staff on the periphery not attending team meetings. However, Ava felt these issues were resolved with the team agreeing to workarounds, '[No issues] *where you couldn't go anywhere*'. Ava fully embraced the ethos of interprofessional practice and did not seem to be fully aware of the issues of positioning raised by other team members.

Liam also reflected how other professions viewed their responsibilities and communicated with each other by remembering a particular instance in a team meeting,

> *"[Another practitioner] and I had a helpful conversation which made me realise that when she put things in a, what I consider a tentative way, she was actually being quite clear. In her mind it was quite clear but the way she put it, I was left with 'well I still don't know' but could this person hurt themselves further by pushing their body hard doing something like that. So that was quite helpful for me to understand that, but again it's partly I think personality and the way we communicate and alerting those differences was helpful" (Liam, counsellor, interview two, lines 80-86)*

Learning through a process of interacting with other practitioners in the team meetings was evident in many of the interview transcripts. As with Liam's extract,

the conversations he had with another practitioner about differences in how they provided information to the clients were helpful. In this extract above, Liam's conversation followed up on the experience he had of feeling fear in the room with a client during a joint therapeutic session (expressed in subtheme 5.2). Liam waited until after the client session to clarify the areas that bothered him. In a display of openness and good team practice, Liam asked these questions openly of the practitioners during a team meeting so that all team members could contribute and learn from the example. This conversation is important in demonstrating the teachable moments provided in the team meetings (occasions when practitioners can take the time to explain concepts from their own profession to others). These conversations allowed an understanding of how other professions approached the same client but from a different perspective.

Amelia provided another insight into how an understanding of the client needs was enhanced by having more than one perspective, which changed the way she perceived her profession,

> *"I mean part of me kind of thinks there is sort of power in understanding your pain and the way your body works. But, I can see that that is just really discipline specific – and I can see the value in what [the counsellor] said as well. Because from the other perspective [the client's] beliefs are kind of survival things for him at the moment and reasons, or his reasoning, as to why he can't work or why his life is not going that way" (Amelia, physiotherapist, lines 190-196)*

In this extract, Amelia is learning how counsellors (a different profession to her own) interpret how the client is making meaning of their situation, which adds

another perspective in how she interprets the clients – a double hermeneutic. Through listening and learning from the way other professions approached the same clients, the complexities of the client needs have become more apparent, and team members learned how professions use this information for decision-making.

Participants described how they could take these different perspectives into their sessions, including sessions outside the interprofessional approach. For example, Charlotte provided insight into her awareness of using a new understanding of physical pain with a client who was not part of this program setting,

> *"So, I had an initial session with one person, and I thought I was listening and asking more about physical pain than I would have normally. And so, it just seemed that would be really useful, with this other client the client that I gave you the example of, you know he started off as a counselling client and two or three sessions into that I said, 'we need to open it up' and so I organised that joint assessment" (Charlotte, counsellor, interview two, lines 75-80)*

This new awareness of the holistic issues associated with chronic pain, and Charlotte's new comfort in suggesting a joint therapeutic session with another practitioner, led naturally to interprofessional collaboration for this client.

In this following extract, Oliver also expressed the ongoing benefits of his recently formed holistic view of chronic pain,

> *"So, its lovely to have that – those bits of knowledge that you can just grab. And it's nice to realise, you realise how much you know because you have*

to explain it to the physiotherapist too. And you kind of go 'oh yeah' because we both know a lot. But you don't know what you don't know until you have to share it with someone else. So, it's cool to be in a room with a client and be able to do a quick demystification about that and just something like, this is depression, this is anxiety, or it isn't anxiety or depression or something, and they can go, now having the pain there doesn't make sense so we think this might be more psychological, or something, still pain but you know something else happening here. It's not, it doesn't make sense with the injury that they are talking about or something." (Oliver, counsellor, lines 220-230)

Oliver appreciated this expanded professional knowledge, drawing on it and teaching it to other practitioners. He also indicated how much he enjoyed having another practitioner that he could rely on to provide additional information to the client that complemented his own.

Similarly, in this extract from Amelia, it is evident that when clients share their psychosocial context with the practitioners, it opened new doors in understanding,

"It's kind of highlighted my ignorance to the thinking about that. That complicated life that people can have there, and also, it's kind of just learning more about the visas and stuff that I can, I know how it's relevant to the access that people have to certain healthcare which I didn't really understand a whole lot before." (Amelia, physiotherapist, interview one, lines 108-112)

In gaining a greater understanding of the client's holistic perspective, Amelia gained a deeper appreciation of how this information could help her to support the client to manage their chronic conditions.

Liam also finds a new awareness of the holistic needs of the clients,

> *"The pain with refugees was kind of something I was kind of aware of was in the background. And I might ask a bit about it, and, oh, they are seeing a physio, oh, that's about as much as we can do and maybe we could talk a little about relaxation or something. But it was a bit of a blur. But now it's also giving exercises and 'Do you want me to talk to [physiotherapist] about what else we could be doing here in the counselling session that she thinks might be helpful for me to do?' So, that's what's happening, I don't think I've thought about it as a formal framework or anything like that, but I think the 'cross-fertilising' if that's a way to describe it. We are broadening our professional vision, if that's a way of describing it - seeing more than we saw before" (Liam, counsellor, interview one, lines 197-208)*

Liam reflects on the actions he would have taken before the Branching Out program. Now, he can identify the growth in his perception of professional boundaries. Liam recognises that the practitioners are '*seeing more than we saw before*'.

5.3 Theme three: Coping with an interprofessional approach

Just as every team has good days and bad days, every practitioner on this team described days they felt inspired to be involved with the program and days they

felt tired, overwhelmed, or undervalued. This theme captures the multiple facets of these day-to-day experiences.

Hazel describes how the practitioners participated in the program and were able to learn from each other,

> *"In particular, I saw with the counsellors and the physio; just hearing them talk at the meetings; that the counsellors just came to understand pain a lot more. The physios came to understand where the counsellors were coming from and were quite reluctant to encourage people to do things because of their lack of that sort of biological side of things and that physiological side of things, and a bit frightened that if they might encourage a person they might hurt themselves. And this just came up in the last meeting that we had. There was quite a bit of clarification there around that. So, it was sort of this light bulb sort of moment that the physios didn't realise that the counsellors were* [working] *with trepidation, kind of encouraging people to do a bit more exercise. Not knowing if they might really* [be doing harm]*, and that's what they were really a bit anxious about. So, it was that sort of cross-fertilisation and that sort of process that's really beneficial. Just appreciating the work that other people do, and how they do it, but also upskilling yourself as well" (Hazel, registered nurse, lines 317-333)*

The time for communication in team meetings was crucial to allow practitioners the learning space they needed when using an interprofessional practice approach. Hazel uses the term *'cross-fertilisation'*, which is the same term used by Liam in

describing the broadening of professional vision the practitioners are experiencing through their discussions in the team meetings.

However, having the time to communicate was recognised as a challenge by all. Liam expresses that one of the main concerns for himself was having time to communicate within the program,

> *"The things that I found difficult around that is finding time, catching up to be able to have that sort of communication with another professional; that you end up with time to do it is tricky." (Liam, counsellor, interview two, lines 12-15)*

There was an increased need for communication within the team. This communication could be formal (i.e. team meetings) or informal (e.g. chats in corridors), both of which many found difficult to achieve. Some practitioners prioritised this communication more than others, leading to frustration for some team members. For example, Liam recognised that without making time for team communication, some practitioners may not have effectively communicated in the best way to meet the client needs, and thus may not have been working in an interprofessional practice approach.

Three subthemes came into view within this theme. The first subtheme, *'Is it too much to juggle?*' emerged from the practitioner's view as they included the interprofessional approach activities alongside their usual care activities. The second subtheme, '*Resistance*', emerged when practitioners found it difficult to comply with interprofessional activities. While the third subtheme, *'Burnout as a consequence of openness'*, emerged from the practitioner's reflections of the interprofessional approach's additional workload and complexity. Each subtheme is discussed in more detail in the following sections.

5.3.1 Is it too much to juggle?

The practitioners who joined the team in this study were experienced in their professional roles. However, not all practitioners felt comfortable when they first started working with the interprofessional practice approach. For some, like Amelia, there were nerves to be overcome,

> *"Initially, I was really nervous about doing the initial assessments, and I felt really, quite out of my depth. But once they started, I realised they were quite similar to what we do in physio assessments anyway, so I kind of felt more confident" (Amelia, physiotherapist, interview one, lines 30-33)*

Like anything new, changes to the way practitioners work in practice can initially be perceived as a threat. However, by trusting the process, Amelia was able to see how this new approach sat alongside her usual approach to care and included her knowledge and experience of her profession, giving her more confidence.

Violet also felt nervous when she first started working on the program. Her anxiety stemmed from having another practitioner in the session with her and not making mistakes or looking unprofessional,

> *"It's been really rewarding, I really enjoyed the [interprofessional] stuff, you know you just have to get used to having someone else there but once you kind of get over that sort of anxiety of, 'oh someone else is there', and 'oh no how embarrassing if I muck up something'. […] I know the* [Branching Out program] *have those really big assessment forms and for me to remember to ask those* [questions from the form]*, and to look over at the other clinician took me getting used to* [doing this]*, and not having to look*

like a doofus[3]" (Violet, exercise physiologist, interview one, lines 19-22; 29-32)

Many practitioners commented on this feeling of being exposed in their early encounters with joint therapeutic sessions. Stepping into a professional space where your knowledge and ways of interacting with clients are visible to your peers is not likely to have been part of their experience since they were in training in pre-licensure settings. Therefore, early anxiety is likely to be a regression to assessment pressure and the associated fear of being judged by your peers. In an earlier extract, Liam's comment suggested he felt the practitioners sitting on the periphery needed to mature to become part of the core team. For many, maturity comes from experience, being vulnerable and overcoming fears. Therefore, the maturity Liam felt was lacking from those on the periphery may be aligned to Violet's feeling of anxiety.

Perhaps the team felt openness with each other was necessary, and it may be that they were able to learn from each other through these new avenues of communication. However, there is also an indication that some practitioners did not verbalise their position or internal struggles. These practitioners held these issues back behind a professional defensiveness wall, hiding behind professional identity to protect themselves from personal judgement.

One of the practitioners who responded with professional defensiveness was Oliver, who stated,

[3] Doofus is a slang term meaning 'a person with poor judgement or taste'.

> *"In terms of pain and physical treatment I probably haven't learnt that much. I've learnt a bit about pain but in terms of physical treatment of that I probably haven't taken up anything more. But I think that the physio's in particular, and probably the occupational therapists, as well as learning a lot from the counsellors, and psychological context and probably spinning a bit with it all" (Oliver, counsellor, interview one, lines 108-113)*

In this extract, Oliver is defending his professional knowledge. He has learnt a little about pain but not much about physical treatment. Professional defensiveness can be a way for practitioners to protect themselves from feeling uncomfortable. In this situation, Oliver may feel uncomfortable about his lack of understanding of physical pain and treatment. His statement that he has not learnt much, but others, such as physiotherapists and occupational therapists, are learning a lot from counsellors indicates that he is aware that learning is taking place within the interprofessional activities. In emphasising that the practitioners are '*spinning a bit with it all*' Oliver is referencing that the clinical and practice approach information he and the other counselling members of the team are illuminating for other practitioners would be having an enormous impact on them.

Similar to Liam, who was being defensive by positioning others not communicating well rather than his need to learn new information, Oliver is uncomfortable about his lack of knowledge pushing him to be defensive. This professional defensiveness leads us to question whether some professions are more guarded of their roles when working with an interprofessional practice approach than others. Alternatively, some professions may have more to give or more to learn as they blur the edges of their roles within the interprofessional team.

In a further extract from the same interview, Oliver again states that he felt the members of another profession (physiotherapists) had learnt more about the client's issue (the complexity of pain) from the perspective of his profession,

> *"So, a year into the project there is a bigger political context there where a lot of these people are here now have been here for a year longer than they had been when this project started and then they are that much more traumatised by the system. And so, psychologically it's just that much harder trying to support them [the clients] and I think the physios are, I think in some of the ways with the groups, they have become aware of what's* [so difficult]*, and how complex this work really is" (Oliver, counsellor, interview one, lines 166-172)*

Oliver reflects on Australia's political landscape at the time of these interviews when people of refugee and asylum seeker background were facing extreme pressure due to loss of political support and the subsequent negative media attention. He felt the clients are traumatised by the Australian system affecting their visa status and social needs. This locally acquired trauma puts pressure on psychological modalities to provide additional support. Oliver speculates practitioners in modalities outside of psychology are becoming more aware of the complexities being thrust upon the counselling team.

Then, in a further extract from the same interview, Oliver reveals that he has indeed been enhancing his knowledge in the area of physical pain, but not from the other practitioners,

> *"Pain was something outside of my area so I have learnt a lot. So, I have done a lot of reading and learnt a lot that I didn't know before, so even*

though I am not a physio like that …so I ask all my clients, probably, about pain now. Whereas I didn't do that a year ago" (Oliver, counsellor, interview one, lines 503-507)

In Oliver's way of defending his professional knowledge (or lack of knowledge), he has turned to read about physical pain. He admits he now knows a lot more than he did one year ago, which has provided him with a deeper perspective. However, in Oliver's case, he has been aware that there is a gap in his knowledge through the interprofessional practice approach. He has chosen to fill that need with external learning, which had also been encouraged by the interprofessional team. This need for external learning support raises whether all professions are equal within the interprofessional team. Does the complexity of the client's needs in this cohort result in differences across the team in requiring support to bridge gaps with other professions, impacting how they engage in an interprofessional practice approach?

Another form of professional defensiveness was demonstrated in a statement from Chloe, who commented on a client who decided not to continue with counselling after the experience of the initial joint therapeutic session,

"A client I saw, and she was also connected in with [another program], and she was an asylum seeker and bored, so I think rather than counselling it seemed she wanted to be better connected with activities. And once that took place the counselling seemed less relevant, and in fact, her pain diminished completely. So, I don't think counselling per se was beneficial, it was more connected with the extra-curricular activities" (Chloe, counsellor, interview two, lines 15-20)

In this extract, Chloe is possibly defending her professional position by rationalising that the client chose not to further engage in counselling due to being satisfied with connections to extra-curricular activities. The joint therapeutic sessions have made the client choices and actions more visible to co-workers and were another way this work could be exposing. Strategies were used to minimise the anxiety this provoked, including professional defensiveness, in the form of defending professional knowledge as not requiring input from others or defending a professional position by deflecting issues onto the client.

5.3.2 Resistance from others

Some practitioners experienced resistance from others to work in an interprofessional approach due to frustration with the change from usual care. Many commented on feelings of frustration derived from time restraints for the number of required activities. A clear example of this was with Chloe, who shared her strong reactions when, during the interview, she was questioned about her interest in attending an interprofessional training workshop,

> *"My initial response is 'oh God not more'. My time is so limited. In theory I think it would be really good. And another thing that came to my [mind], is 'oh my God, I would need to have that time to do that' So, there's something I guess if we do step into this way of working it feels, whilst productive, it feels more time-consuming in some ways. So that would require a kind of rethinking about how we work too in regard to our caseloads and other commitments - because we can't do it all" (Chloe, counsellor, interview one, lines 133-142)*

Chloe's initial response was palpable, an immediate sense of needing to protect her time that she felt was already at risk. Chloe is open to identifying her needs to perform her role and called out what she could see as the real issue; the lack of time available for her to commit to being immersed in a new approach requiring training and ongoing processes.

In her second interview one year later, Chloe stated that she was aware she was not as in touch with the interprofessional team as she should have been,

> *"There is probably part of my lack of appointments I have offered, but also not attending them, those meetings. So, I'm out of the loop a little bit. I kind of stepped in because they needed more counsellors, so I said, 'yes I will help', and so, if I was here on the Thursday that would be, another meeting (laughs), I would have to attend." (Chloe, counsellor, interview two, lines 100-104)*

Chloe reflects on her decision to be available for the Branching Out program to help out, yet she is torn as she felt that she does not have the time required. Chloe has set limitations on her time allocations to the new way of working, but the cost was that she remained on the interprofessional team's periphery. Chloe did not feel she had the authority to reprioritise the Branching Out program over her other commitments. This choice to maintain limits as protection from burnout is essential to identifying processes that create sustainable work settings.
Oliver adds further perspective on why the Branching Out program is time-consuming,

> *"So, just coordinating when the client can come, because they have got English classes and life, and we have all got meetings and things. So,*

there might be a delay of a couple of weeks because you can only get one time that works for you all to be together in a room, so that's probably the… So, we have a schedule over the week, this is when we have our team meetings, this is when the intake appointments are. That's kind of working fine and I think we have all managed that, but it's after the intake session I think that we all go – 'So, what is our next step', and if you are trying to coordinate something with your colleague that's the hard thing (…) none of us are full time (…) Look it just takes more time to talk about clients when you are doing it with others. You know trying to coordinate and brainstorm and, I mean that's its great advantage because you get to share it and you go - waa waa waa[4] – and, but the disadvantage is that is just takes more time "(Oliver, counsellor, interview one, lines 353-368)

Oliver finds each stage of the coordination with the client and the other practitioners to be complicated. Additionally, Oliver is frustrated that he cannot give the clients all the time he would otherwise be able to give if not bothered by coordinating physical modalities in their care plan. Oliver is working through the benefits and drawbacks of working in an interprofessional approach. On the one hand, he could be more efficient on his own, but on the other hand, there is an advantage in sharing information with others.

Oliver extends his view of an interprofessional approach being beneficial,

"So, it's kind of like, something about the pooling together of the physio and the counsellor and say the [client name] experience. It sort of changes a bit about how you work and how you understand what, within the limitations

[4] 'waa waa waa' is a colloquial expression for a lot of talking

that we have got here and a short amount of time, what is going to be useful for her" (Oliver, counsellor, interview one, lines 264-273)

In this extract, Oliver felt the pooled information allows them to decide the best way for the client within the time constraints and the program's limitations. While other comments from Oliver pointed to him struggling with the program's relevance, this extract highlights that from some perspectives, Oliver finds it can be useful. For Oliver, this tug-of-war between the program usefulness and a waste of time is very much case dependent. It may reflect the complex clinical and psychological needs of this specific client group.

5.3.3 Burnout as a consequence of reluctance to change

The phenomenon of practitioner burnout has been determined to have many causes, including emotional exhaustion, depersonalisation and heavy workloads. For example, practitioners who are under pressure to fit more tasks into an already busy schedule may become overloaded and feel unable to cope. This subtheme identifies the practitioner's feelings towards the complexity, and time-consuming nature of the interprofessional approach in this care setting, indicating that the practitioners may have been at risk of burnout.

The following extract from Oliver showcases the practitioner's feelings about their workload being affected by the types of clients in the program cohort,

"The nature of working with asylum seekers is really, really, it's tough. It's really tough, and I think the counsellors are really aware of the psychological context of it. We knew it already and, look a year later all the

political side of it, they are more and more ground down psychologically and more fragile" (Oliver, counsellor, interview one, lines 162-166)

Oliver voices the feelings of many of the practitioners working with clients of refugee and asylum seeker background. The client cohort presents to the community health centre with complex chronic conditions. They also belong to a group of people who have been on an arduous, often traumatic journey leaving their homeland behind. Additionally, Oliver felt that Australia's political context deepens these psychological wounds, making clients from refugee and asylum seeker backgrounds more fragile and, therefore, less able to develop strength in themselves to cope with the issues they are facing.

In this extract from the same interview, Oliver then speaks of a deeper level of struggle that both the practitioners and clients need to work through,

"And look there's a struggle in a health centre where you have your own professional code of ethics and the health centre has a value system. You know that is your value system about human rights and dignity and interprofessional practice ... and all the things that represents. And then you are up against a political climate at the moment with the Department of Immigration that is actually actively oppositional to that and is prepared to harm clients through a different means and for a different goal. But they are actively harming people and we are meant ... we are trying to counter that. We are trying to present a human face but ... we are not winning in terms of the bigger picture. And so, in terms of Branching Out that's tough" (Oliver, counsellor, interview one, lines 186-195)

Oliver speaks passionately about trying to counter the government's values with a human face. Managing this type of battle on a day-to-day basis requires the activation of several different coping strategies.

Amelia also finds the clients have distressing stories which are challenging for the practitioners to cope with,

> *"Maybe the assessment is a really big assessment to find out that someone is not appropriate – and I guess, [client name removed] it was quite confronting because we went through an hour and a half of this really quite, you know, quite distressing story and .. that case it was very challenging for me" (Amelia, physiotherapist, interview one, lines 142-144)*

For Amelia, it is confronting to work with a client in this cohort in a joint therapeutic session for the program's initial assessment component. The initial assessment is longer than usual for the practitioners as well as for the clients. Amelia also felt that working through this long assessment with a client is especially difficult if the client decides not to continue in the program or the practitioners determine that the program is not suitable for the client. Other signs of additional strain on practitioners include frustration when clients do not continue with both professions, as indicated by Violet in the extract below,

> *"With interprofessional practice sort of stuff with clients, you know, you go in with the best intentions of interprofessional practice and the clients might not want interprofessional practice, you know. I remember one client that with Branching Out said, 'No, I just want physio', and you are like okay. So, even though you tried your best to sell it like they are just not interested like they just want one particular discipline.*

Yeah, it's everyone's preference and what they feel is important for them. So, it can be a bit challenging you know so you have spent the time with the assessment and then they don't want it, and then, Ahhh … oh well" (Violet, exercise physiologist, interview one, lines 238-249)

Violet is frustrated that she was trying to encourage the client to continue with clinical sessions in exercise physiology, but they declined. Violet's attempts to motivate the client to accept this service had a more evident sales pitch to it than expressed by other practitioners. Although exercise physiology is a relatively new modality, most people can relate to this service's aims quite quickly, so a rejection may feel that it is singling out a particular practitioner as not useful. While this is a professional rejection, it can still bring distress, especially when done in a co-worker's presence.

For some clients within the Branching Out program, a limitation was in place on the number of sessions they could attend. Aurora held a role within the program where she was required to notify the clients when they had exhausted this allocation of sessions, which she found challenging to do,

"Makes it difficult, when we've had to say you know this is the last session, and we went through all this, but we need you to go back and have another assessment with physio and what have you. You need to go back and be talking to your doctor and counsellor and then this and this happened. And so, 100% of them said: 'So, when can we start coming back', and I said 'No' and we had this big long conversation with a couple of them and explained that at the moment the money isn't there and - you know" (Aurora, remedial massage therapist, interview one, lines 265-271)

Having reached the organisational boundaries placed on this service within the Branching Out program, Aurora found it challenging to break up a relationship with the client that was so hard to build.

Another stress factor that can lead to burnout is emotional exhaustion. In this extract, Liam expresses his feelings of fear for the client, which align with the client's fear,

> *"I'm listening to [physiotherapist] assessment of it whether there's – whether she's, if there's any risk of further .. because that's what the clients fear the most and that fear is projected in the room and you know, I don't have a physical reference point. It's very easy for me to feel like the client's feeling – quite worried that we're going to do more damage." (Liam, counsellor, interview two, lines 86-91)*

Liam is concerned while listening to the physiotherapist, encouraging the client to undertake physical exercise when the client fears this may result in more damage. Liam's reflection of the incident depicts himself being aligned to the client's fearful emotion, therefore not aligned with the information being provided by the second practitioner. In an interprofessional approach, the two practitioners need to support each other, helping the client overcome any fears by providing complementary information from different professional viewpoints that may help the client understand the information being provided. In this scenario, the mutual trust between the two practitioners is lacking, perhaps showing that Liam's fear is aligned with a reluctance to blur his role with that of the physiotherapist.

However, this moment was set at an early stage for the interprofessional program. It may be that Liam was able to overcome these fears with experience and build

his knowledge base from others. For example, in an earlier extract from Hazel (5.3 Coping with a new approach), it was revealed that the practitioners discussed issues such as these in an interprofessional team meeting allowing practitioners to learn more from each other and clarify areas that may have caused concern.

Chloe also acknowledges the problematic struggles the practitioner's must workaround as part of the interprofessional practice approach. She suggests the need for multiple support strategies which can help to alleviate burnout,

> *"And a part of this, we offer regular supervision; we are committed to regular supervision, so most of the counsellors have supervision every fortnight. So, there are lots of avenues of support" (Chloe, counsellor, interview one, lines 67-68)*

In the extract below, Charlotte identifies the need for the practitioners to take individual responsibility for managing change,

> *"I think that's evolving because we have had different ways of doing things. And, at the moment I think [practitioner name] has taken a lot of responsibility for a lot of things. So, she is sort of driving the project, but I can see that unless we start to come up with our own ways of .. our own procedures .. things might fall in the gaps. So, there's things that are coming out that are new that we are just addressing as we go. So, I think that part is still not clear, and as things happen we just address them" (Charlotte, counsellor, interview one, lines 47-55)*

Charlotte expresses the need for all practitioners to address issues as they occur and find ways of working that will better align with the interprofessional practice approach.

5.4 Theme four: Finding the balance for the client's benefit

The fourth major theme emerged from the practitioner interviews related to how the practitioners felt concerning practice in a team setting with the client and how they perceived the client's response. The first subtheme, *'Building trust with a holistic approach*', aligns with the mutual trust developed between themselves and the clients. The second subtheme, *'Barriers to be overcome'*, aligns with the obstacles and burdens the clients brought with them when attending sessions as part of this study setting. While the third subtheme, *'Is the interprofessional approach beneficial?'*, highlighted the practitioner's issues regarding the ethical and moral considerations of an interprofessional approach in this care setting.

5.4.1 Building trust with a holistic approach

The practitioners told anecdotes of their clients expressing gratitude. For example, Aurora gave a powerful example of the importance of treating clients as humans who matter,

> *"The ones I saw for the remedial massage all said that they really, really thought that it was working for them, that they felt that they were. One of them said some words like they just couldn't believe that they thought, or that we thought that they were important enough that we were all going to work together with them. So that was, I can't remember what her words*

were now but, I'll try to remember that and write it down [to provide later]. The fact that all these people were concerned about her and her welfare and her ongoing care, that we were all spending all this time working with her." (Aurora, nurse, remedial massage therapist, interview one, lines 171-176)

Oliver also comments on the client's feelings of being surrounded by a team,

"I think the clients really appreciate having a sense of team, or something wrapping around them a little bit." (Oliver, counsellor, interview one, lines 394-395)

In each of these extracts, Aurora and Oliver refer to the clients feeling of a team surrounding them. Aurora notes that the clients '*couldn't believe we thought they were important enough*', which suggests they are unfamiliar with this type of care and feel it is more than they would expect. Oliver notes that the team is '*wrapping around them a little bit*' which paints a picture of a warm hug or a protective layer the practitioners provide to support the clients in their health journey. Both of these practitioners noted that the clients feel secure and appreciative of care within the team. This client feedback suggests that mutual trust was developing between the clients and practitioners as the program unfolded.

On the other hand, Liam paints a picture of distrust between the clients and the practitioners. This distrust may have been set up by an early mismatch in expectations of the goals of the program,

"Effectively, we are dealing with refugees and asylum seekers that have chronic pain and in most cases looking for some kind of physical... They see it as a physical issue, so they are looking for a physical remedy and

they are being referred to us because it's felt it's not a physical issue and the physical approach is not going to resolve it. So, immediately, with almost every referral you've got a mismatch between what the client feels is the issue, and what we feel is the issue, there's a mismatch between what they are looking for and what we are offering – so a lot of the work has been kind of pre-intervention work. It's kind of talking about what it is we have to offer and why they have been referred and whether they can see much sense in what we are proposing and would that approach seem to be useful for them and that kind of thing. So, for some of them they have been able to make that shift, to realise that there may be psychological, social, and other factors influencing their pain. And some have just been absolutely, 'No way - what are you talking about'. And they've just wanted to reject the approach outright." (Liam, counsellor, interview two, lines 55-69)

Liam expresses frustration with the communication being provided to the clients before they attend the program and how they are referred into the service. His frustration is felt when he acknowledges that other practitioners have identified the clients' holistic needs but not explained this to the clients in a way they can understand. Liam infers that a referral to the Branching Out program is the other practitioner's way of passing this problem on to someone else. The amount of work this mismatch in expectation creates for the practitioners in pre-intervention work is frustrating. As a counsellor, this situation can immediately shut Liam out from having any input into helping the clients. The program is designed to offer both physical and psychological support in a combined effort to help the clients move forward. However, some clients reject this approach due to the mismatch in

expectation of what the program can provide for them. For Liam, this rejection is sometimes felt to be absolute from the client as they reject going forward in the program, leaving the counselling team's role out of the client care plan.

All clients bring some sense of uncertainty when seeking care by the very nature of requesting help for something unknown. The ongoing development and nurturing of trust between practitioners and clients is essential to help clients manage the feelings that come with this sense of apprehension. Within the interprofessional practice approach, some of the practitioners commented on the development of trust by the way they recognised a change in the client's sense of themselves,

> *"I think it's a sense of, I'm not sure what they would say if you asked them, I think there is a dignity that that bestows, a sense. I think they have a different sense of themselves just by the respect I have of that, especially for women, I think for women to be asked, this is what we can offer, what would you like – you know you are free to take all or none or some. You know I think that's psychologically just an empowering experience in itself. It's therapeutic in its, by the very nature of it" (Oliver, counsellor, interview one, lines 431-437)*

In this extract, Oliver guides our attention to several areas of trust development within the program. He has recognised that the clients have a different sense of themselves because the program has provided them with dignity and respect through the practice of shared decision-making. By phrasing his comments in this way, Oliver is alluding to the client's experience in their home country where a women's right to choose may not be possible. So, to be immersed in a setting

where choice is available, such as the shared decision-making philosophy in the interprofessional approach, is therapeutic in itself.

On the other hand, Aurora is not sure that the clients in the program were able to comprehend their right to a choice, and therefore be able to build trust in their treatment plan,

> *"Some of them actually said things like they were all grateful. I think the overwhelming gratefulness was quite - which is something which I have experienced before. It's difficult to get them to be critical about what care they are* [receiving]*. I think they just want to; they always want to tell you it's great and it's wonderful da-da-da. But to get them to break it down and they don't want to offend you and that sort of thing" (Aurora, nurse, remedial massage therapist, interview one, lines 165-166)*

Unlike Oliver's comments referring to the client's appreciation of options provided through shared decision-making, Aurora alluded to a different message in this extract. She felt the clients were overwhelmingly grateful for the care they were receiving, but at the same time would find it difficult to be critical of the approach used in this care. Similar to the insights provided by Oliver, Aurora is also implying that the client's cultural background and healthcare in their home country are different from what they are experiencing in Australia. Nevertheless, rather than enjoying new freedom of choice, the clients are bound by their cultural servitude and cannot state their true feelings about the interprofessional practice approach.

The practitioners who are now more experienced in the interprofessional practice approach have become more aligned to the clients' holistic needs. They find it

frustrating that others in healthcare roles do not respond with the same respect for their needs. Even when advocating for the clients, they find a sense of helplessness when dealing with the broader system. In this way, the practitioners are feeling the same sense of frustration that the client is feeling.

5.*4.2* Barriers to be overcome

The practitioners within the Branching Out program commented on barriers clients faced in order to attend the program,

> *"The challenging things for most of these clients is actually having enough energy and motivation to actually turn up to the appointments whenever they might be, because of the huge stress levels, they are just overwhelming stress levels. The asylum seeker clients I noticed more than the refugee clients, the level of stress was just excruciatingly high so for them to actually turn up for any appointment was a pretty major thing" (Aurora, nurse, remedial massage therapist, interview one, lines 152-155)*

Aurora notes the elevated stress levels of clients with asylum seeker status, making it more difficult for them to attend sessions. Oliver's earlier extract brought attention to the additional strain brought on asylum seekers by the Australian government. However, unlike Aurora, Oliver felt that part of the practitioner's role was to help counter this additional stress. This difference may be based on the roles and responsibilities Aurora and Oliver have within the interprofessional program due to their professional background. Although Aurora is not a

counsellor, the interprofessional approach should allow her to lean into the support (accept and utilise the support) from the counsellors on the team.

Another barrier the practitioners commented on was the client's belief that they needed to attend the sessions based on another authority telling them to do so instead of their healthcare desire. Chloe reports on this issue,

> *"I know that with the last client that we saw, she didn't know why she was there. So, there are issues around why they are there, but often with the clients being asylum seekers or refugees it looks authoritative, they don't want to not go to the appointment. So, they turn up. So, there's a compliance there, but whether it's because they want to be there or not I don't know. I think you know we don't present it; we always present it as a choice, are they interested? So, sometimes I wonder about clients saying yes when they are really meaning no" (Chloe, counsellor, interview two, lines 154-161)*

In this extract, the client's cultural background may be a barrier to developing mutual trust, but Chloe is also externalising the problem instead of taking accountability for individual client needs.

5.4.3 Is the interprofessional practice approach beneficial?

The practitioners have expressed varying views of how they perceived the clients responded to the interprofessional approach. They considered some clients felt unique and special, some felt overwhelmed, and others felt an outright rejection of this team-based approach. Based on this wide variation of responses, the

practitioners reflected on the programs overall benefit. Ava's comments provide a summary from her perspective,

> *"There can be assumptions that, it's all great, and we have this thing to offer. So, therefore, you know, the client should love it and it should be really, really good for them. So, there's that approach or the other approaches. Oh, you know the client experienced trauma. There's no way that they could manage, being in a situation with two practitioners, so we won't offer them that opportunity so. I think it's really interesting to explore because both ends are probably not correct. Obviously, it's you know, depends on the individual client and that's the main thing, and it really depends on the individual client" (Ava, physiotherapist, interview two, lines 659-667)*

Ava is making the point that it is easy to make assumptions of whether the program should be beneficial to the clients. However, we should never make assumptions for the clients. Instead, we need to make the program tailored to the client's needs.

From an organisational view, Chloe felt the Branching Out program provided an advantageous position for the clients being referred to the program, leaving other vulnerable clients in a lesser position,

> *"I hold the waitlist, and that's the nature of it. You know the assessments; it's about offering immediate care. But then it prejudices those clients or favours those clients from those that have been waiting eight or twelve weeks. Now I don't know how to get around that, but that is the dilemma. There are clients waiting for longer now because it's just we are working*

with scarce resources, that's the reality, how to manage that. And if a client comes in for an assessment then obviously there needs to be an immediate follow up" (Chloe, counsellor, interview two, lines 81-85)

For Chloe, this perceived bias adds to her angst about the interprofessional practice approach.

Some practitioners commented on how they would feel had they been a client. Liam felt the clients are attending the Branching Out program as a fresh start to finding relief, putting a lot of pressure on the interprofessional practice approach to meet these expectations,

"There is a team, not just one person but several people all focused on getting them well, and I think too there is a readiness. If they are at that point where they are ready to make that shift in thinking then, I think it feels like a good [program of care] - that they are getting some help - because they feel they have gone down a path of medical intervention where they haven't been able to get the result that they have been looking for, and perhaps getting to a point where they feel like their doctors etc are kind of giving them hope of getting results, so they haven't [been getting the results they hoped for]. It's like a bit of a fresh start for them [the Branching Out program]. But again, it feels like there is a lot of pressure to deliver some results" (Liam, counsellor, interview two, lines 197-205)

The pressure to deliver results for the clients can be an additional burden on the practitioners, who are still learning how to work within an interprofessional practice approach, raising questions of appropriate support and training.

Some practitioners commented on the new roles and responsibilities for practitioners within the interprofessional practice approach and the benefits of these activities over usual care,

> *"I think [interprofessional practice] is, it reduces that sort of overlap and you, it's quite clear who is doing what. For the client and for the practitioners and just for the client not having to go over their story and their history and their background. I think that's where a case conference too is really good because it just sort of, it highlights for the client that everybody is informed, and they are all supporting that person with the one or two or whatever goals. And it's good for the practitioners to know who is doing what, you know if it needs to be, like if I am doing something for example in that case conference then it is good for people to know who is going to action that. So, it helps pull it together" (Hazel, registered nurse, interview one, lines 453-464)*

Hazel notes that the practitioners and clients were clear on each member of the team's roles and responsibilities which were informed by the client case conference. Another benefit was that the client's history was shared throughout the team, ensuring that the client was not required to repeat their story on multiple occasions. Hazel highlights that the teamwork and sharing of information are known to the client, providing them with confidence that each team member supports their care goals in a coordinated care plan.

One of the significant issues discussed by practitioners was how they felt towards the program when clients did not choose to continue with the interprofessional

practice approach. Chloe was critical of several clients who did not continue with sessions after the initial joint therapeutic session. However, she notes,

> *"You don't really determine that [client readiness] until you are sitting in the session with the client" (Chloe, counsellor, interview two, lines 272-273)*

Chloe felt that although some clients may not choose to continue with the program, it is challenging to determine which clients will choose this path. Therefore, the initial joint therapeutic session is seen as an extension of the intake process with a shared decision to proceed or not at the completion of this session after clients and practitioners have learned more about each other.
Furthermore, Ava provided comment on some benefits to the clients attending the initial assessment session even if they do not choose to continue in the program,

> *"But yeah, there might be a sinking feeling around that [client name] has decided not to continue with counselling, but I think also there's some comfort in knowing that if you're working with that client, and you are reaching challenges in that sort of psychosocial domain that you could potentially reach back out to the counsellor for a secondary consultation or whatever. So, there's an extra level of support for you that may not have existed previously" (Ava, physiotherapist, interview two, lines 343-348)*

In this extract, Ava notes that even though the client is not ready to continue in the Branching Out program, the practitioners who took part in the joint therapeutic session can still reinforce each other. This support would not have been available in a usual care situation.

In contrast, Ava also adds another position,

> *"What would have happened if the counsellor wasn't sitting there? They would have been referred to counselling anyway, because they failed at physio and we think there's a psychological issue going on, so I'll refer you over there" (Ava, physiotherapist, interview two, lines 689-692)*

Ava suggests that if the program was not available, the clients would have continued in the siloed service, separating the physical and psychological without capturing the holistic nature of an interprofessional approach. Ava is not suggesting this to be a better option but highlights that the client's barriers or mistrust of one profession over another would not have been avoided.

In this following extract, Charlotte reflects on whether the intent of the interprofessional practice approach is clear for the clients,

> *"The first question we have is just how clear is it for the client? This program for them. But, I think that in some cases there is enough of a repetition of things for them, to perhaps know that it is working together" (Charlotte, counsellor, interview two, lines 211-213)*

For the program to be useful for clients, they need to understand its offering and engage with that offering. Charlotte reflects on whether the practitioners have effectively explained and explored the clients' options within the interprofessional practice approach. Charlotte notes that the practitioners have made many attempts to provide repetition within the program to reinforce with the clients that the opportunity they have been provided is to work within a team environment that

is different from their usual care. Charlotte felt that the activity of the practitioners collaborating is the program's unique focus that needs to be clear for the clients.

In her second interview, Charlotte is quite passionate about her concern that the practitioners remain centered on the client's voice in the decision-making component of the program,

> *"Well the clients understand what we are offering and that they don't have to take the whole lot, that they can choose what parts or not that they want to engage with, and I suppose in some ways we need to think beyond what we as a team can offer and just perhaps expand that idea, including other services or into that case (care) plan. So just making sure we don't get lost in what we think; that the client knows that they are the ones that ultimately decide, and guide based on what they want" (Charlotte, counsellor, interview one, lines 86-92)*

Charlotte is cognisant that the clients must have a clear understanding of what the program is offering and how they can interact within the scope of the options provided to them by the practitioners. Charlotte raises a contention in how the practitioners both need to think about widening the program's scope while also remaining centered on the client choice to decide and guide these choices. Charlotte comments, '*just making sure we don't get lost in what we think*'. The intonation in this phrase indicates that Charlotte has some concerns that practitioners may overthink the program; for example, anxiety concerning pleasing management of the program's success may lead to practitioners placing greater priority on the interprofessional approach than is warranted. Over-anxious behaviour may lead practitioners to bias the way they may position or recommend

these options to the client, essentially reducing the client's agency in the care plan's decision-making. For Charlotte, the client's ability to be supported in choosing what options to accept and not accept is central to the benefits of an interprofessional practice approach over usual care.

Charlotte's view of the benefits of an interprofessional practice approach contrasts with others who, for example, expressed relief when the client did not wish to continue in further sessions after an initial joint therapeutic session. These differences reflect the practitioners focus on whose needs are being met with an interprofessional approach. The program framework allows the practitioners to feel the inconsistencies and challenges of the broader context of healthcare for this client group. While some, like Hazel, take on a personal responsibility to advocate for the clients and lodge complaints when the frustration is overwhelming, others do not see it as their problem to get involved. In this way, the practitioners demonstrate their personal decision on how engaged they have become with the interprofessional practice approach.

5.5 Summary of this chapter

Overall, the practitioners in this study expressed that working with an interprofessional practice approach was not made up of all positive episodes, nor was it filled with all negative experiences. The four major themes that emerged from the practitioner interviews were centered around differences based on everyday exposures to contrary experiences.

For many of the practitioners, being part of the program took individual resilience to keep going daily. Many noted that sometimes the small things needed a lot

more time and perseverance than usual. The practitioners had to challenge themselves to work in front of others and ask each other questions without worrying about appearing incompetent in front of their peers.

Some practitioners became immersed in the program, feeling a sense of belonging to a mini-team (in-group) within the broader community health centre. Others did not become immersed, staying on the periphery by not making themselves available for session times with clients and so were not included in client teams. Similarly, some practitioners stayed on the periphery by not attending interprofessional team meetings.

When reflecting on the clients within the program, practitioners stated that they were *'the hardest of the hard'* and were overwhelmed listening to their trauma stories. It was difficult for many practitioners to comprehend the impact of the pain and trauma on the client's lives. After spending more than a year within the program, most practitioners felt that they had a bigger picture of the clients' holistic needs and could see where their professional knowledge fits in and how their capacity to help has expanded. Examples of practitioners who were experiencing enhanced stress and anxiety from the interprofessional activities were provided. These experiences were linked to potential moral distress.

The four major themes that emerged each affected how the practitioners worked within the interprofessional approach of this study. Due to the counterpoints raised by many of these experiences, practitioners questioned the interprofessional practice approach's ideals as a beneficent health intervention for the clients in this study setting.

Chapter Six: Client analysis

The chapter begins with personal reflexivity and then provided the findings from the IPA of the client's interviews. Three major themes emerged from this analysis, 'The person beyond the pain', 'Opening up to others', and 'Ready to move on'. Each theme was revealed with two subthemes.

The chapter presents the analysis of the findings within these themes and subthemes, alongside the researcher's interpretation of these findings across cases as outlined for an IPA review by Smith et al. (2009).

"To be called a refugee is the opposite of an insult; it is a badge of strength, courage, and victory."

(John L., student, Tennessee Office for Refugees, 2020)

Before I started this research journey, I had limited contact with people who had trekked the difficult path of being an asylum seeker. However, the short contact I had was very personal and revealing and occurred when I was a producer for a short documentary film. The people I met invited me into their homes and told me stories of their path to Australia and their new way of living. They were from proud communities from a homeland severely damaged and experienced a significant life loss. However, they planned to build a new community with the same warmth and strength in their resettled home in Australia. This experience reinforced my understanding that people of refugee and asylum seeker background deserve the utmost respect for their courage, their strength, and the way they bind themselves together into communities like families, whether they were closely related or not. This sense of community kept them safe and helped preserve their culture.

Nevertheless, these earlier encounters had not prepared me for the experience of interviewing the clients who were part of the Branching Out program for this thesis. The clients in this study had significantly more pain in their eyes. They had been through more harm than I could have imagined. Even so, I found myself feeling connected to their stories full of everyday interactions, family, and friends, of tangible things gained and lost. Interpreters were needed to understand each other's words, yet an understanding of each other's gestures and expressions needed no help with interpretation.

Some clients leaned forward in their chairs and touched me on the arm when they listened to the interpreter tell me their truth to make sure I knew this was important to them. Some clients laughed. With one particular client, we laughed together so loud that others in the community health centre may have wondered what we were up to. The laughter was refreshing, but it was also full of pain. Some clients cried when they told me their experiences - a releasing type of tears. I wondered if we should continue the interview, but they insisted it was okay. They then told me how they had cried for the first time with the Branching Out practitioners, so their tears with me made me feel accepted as someone they could trust. There was freedom from a suspicion that the clients were extending to me as part of their Branching Out program's experience.

My plan for the interviews that required an interpreter was to focus on the clients - to allow the interpreter to sink into the background in the room between us. This plan held for the majority of the time. I maintained eye contact with the clients until the interpreter would say something that the client responded to, and the interpreter responded. My attention was then focused on the interpreter as another person in the conversation. I was curious to understand their exchange. The clients did not seem to mind this three-way conversation. I had the feeling that it was part of their traditional way of interacting with people within the community health setting. The clients who did not require an interpreter found it easier to emphasise the points they wanted me to understand, but all the clients found a way, through an interpreter or not, to draw me into how they were feeling. The diversity of these client experiences is captured in this findings chapter and interpreted through IPA.

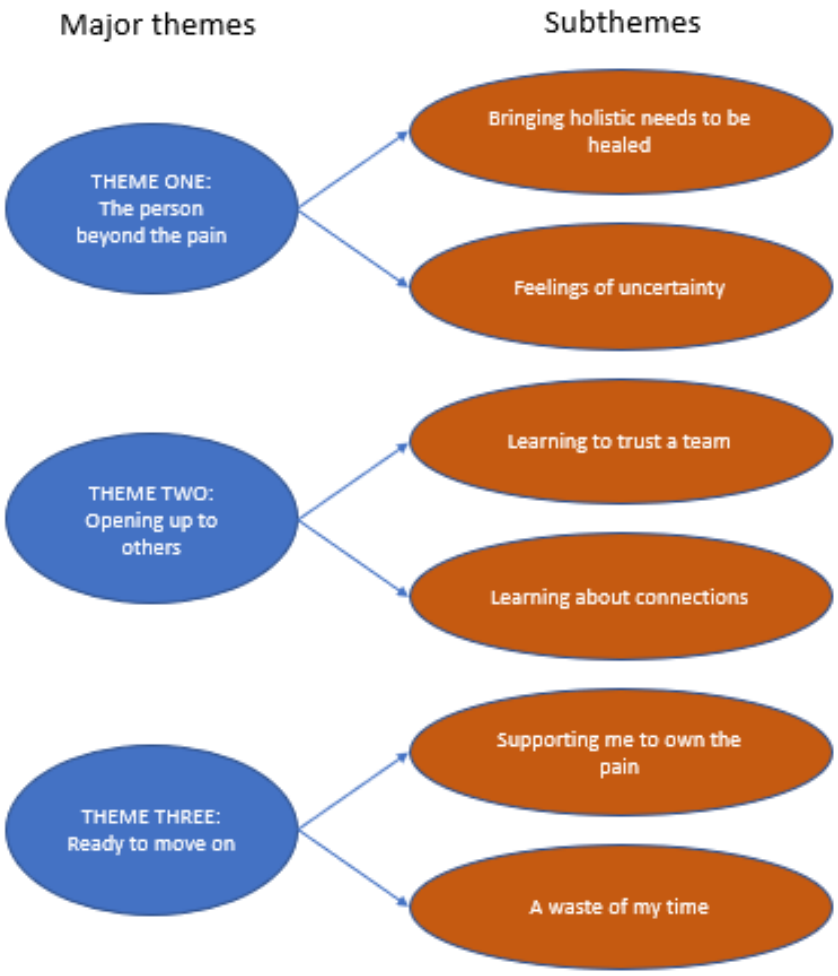
The client's background information is provided in Table 6.1. A pseudonym is used to represent each client to protect their anonymity. As with the practitioner interviews, when assigning pseudonyms, an effort was made to choose ones that reflected the culture, ethnonational background, and original inflection of gender (Allen and Wiles 2016). The pseudonyms were generated in a three-step process. The original name was entered into a name encyclopedia (Namepedia.org) to derive the name's origin. A random name generator was then used (Behindthename.com), utilising filters to select the origin of the name and the client's gender. The random name generator provided a list of five suggested names. The researcher selected the most suitable to fit the client, avoiding names that started with the same initial letter as the original name and balancing the pseudonyms to differentiate from each other easily.

Table 6.1 Clients background information

Participant Pseudonym	*Cultural background*	*Gender*	*Use of interpreter for the interview*
Basia	Italian	Female	Yes
Mahavir	Hindi	Male	Yes
Fjolla	Albanian	Female	Yes
Saam	Persian	Male	Yes
Golzar	African, Greek, Ethiopian	Male	Yes
Efua	Persian, Iranian	Female	Yes
Arya	Persian	Male	Yes
Tetyana	English, Italian, Portuguese	Female	No
Anneli	English, German, Spanish, Finnish, Italian	Female	No

Three major themes that emerged from this analysis were, *'The person beyond the pain', 'Opening up to others', and 'Ready to move on'.* Each major theme was comprised of two subthemes. These major themes and subthemes are shown in Figure 6.1.

Figure 6.1 Client major themes and subthemes



Each theme and its subthemes will now be outlined in detail.

6.1 The person beyond the pain

The first major theme to emerge from the client interviews reflects the needs of the clients as they came to the community health centre to be healed. This theme highlights the client as a person with thoughts and feelings and their expectations of the program. For some clients, their previous encounters with healthcare providers in their home countries or Australia were not reassuring or valuable. The clients brought these memories and their cultural expectations of healthcare

when they sought help from their physician or the community health centre and were referred to the Branching Out program.

Two subthemes emerged within this theme of needing to be healed, which encapsulate the client's feelings as they started their care in the program, *'Bringing holistic needs to be healed'* and *'Feelings of uncertainty'*. These subthemes are explored below.

6.1.1 Bringing holistic needs to be healed

The biopsychosocial layers clients brought to the practitioners to be incorporated into their holistic healthcare plan are examined in this subtheme. Although the reason for referral may have been chronic pain, the program was designed to support these holistic needs by helping clients understand where their chronic pain originates. For some clients, these holistic needs include emotional distress, as explained in this extract from Tetyana,

> *"[client] Upset, yes, because main thing I just felt, a little bit embarrassing, because in my life lots of things happen, lots of things, two husbands a couple of times, got married, not successful. I changed my religion and my family. They left me…Somewhere I felt embarrassing and very lucky (as a survivor). When she [counsellor] started, she told me, 'you're strong, you have strength, you made your decision, facing your problems by yourself' then I, then my strength comes up. Then I saw it slowly, slowly, it takes time, it takes, it took a long time. But these days I am feeling much, much, better because of the physio and the counsellor" (Tetyana, lines 297-314)*

In this extract, Tetyana describes the stigma she felt about her life, making seeking help very difficult. However, she found the process of talking about it helps as she was being encouraged by the counsellor to find her strength. Being listened to and being seen as a person who overcomes so many challenges was important to her. The feelings Tetyana was carrying because of past incidents were a source of a great deal of psychological pain. This psychological pain needed to be addressed to manage her physical pain effectively.

The clients trust in the community health centre was occasionally showcased in how they would ask for help from the practitioners and sometimes from me during the interviews. Basia was one client who did this, bringing a letter along in her bag, waiting for a chance to ask if the interpreter could read it for her. The letter was a confidential document from the hospital requesting her to call. The interpreter did this for her, and then we continued with the interview. In this way, Basia was trusting, seeking guidance, and had learnt that she could trust the practitioners in the Branching Out team, which she is was extending to me.

Arya also sought help from me during the interview. He provided me with details of his visa status and asked for help. I advised that I could not step in with any advice, but I was cognisant of the trust he has placed in revealing this information.

Fjolla also provided an example of trusting me in revealing personal information during the interview. Fjolla provided information about herself, her family, and their living situation. She opened up about many things, including pressing legal issues and minor repairs needed in her house. Ultimately, Fjolla is hoping that the practitioners will help her, and she is reaching out to me as a conduit to the practitioners. In this way, Fjolla includes me as part of a trusted network within the

community health centre and builds on the holistic knowledge she first provided in the initial joint therapeutic session.

6.1.2 Feelings of uncertainty

The client's previous healthcare experiences to examine the uncertainty and fear of healthcare providers that they brought with them into the Branching Out program are explored in this subtheme. Fjolla provided an example of a client's negative preconceptions of healthcare as she recollected her experience of healthcare before arriving in Australia, which she contrasts with her experience in Australia,

> *"[client/interpreter] So, while in [home country] then, when she had the accident – it wasn't easy then for her to go to the doctors, to [preferred/spiritual] doctors, or to go [home country] doctors. Whenever you go, visit them they say come tomorrow or come the day after tomorrow or something. And some of them get postponed quite a lot – and then some of the family members somehow didn't accept it – what she is going through – and it was really hard. And then arriving here in Australia, the health, or the doctors, or whatever, the health is much better, and she's finding that good, and that part she is really positive." (Fjolla, lines 167-174)*

In this extract, Fjolla identifies her struggles to have her experiences validated in her country of origin by her family and care providers. This experience is typical of many clients with chronic pain as the pain is often an invisible disease to others. Fjolla found, in Australia, the surety of knowing that she will have her issues

addressed by a health practitioner when she needs one was an essential first step to building trust in the health system.

In an earlier extract from Fjolla, we can sense a fear of the directions provided to her by a practitioner in her home country,

> *"[client/interpreter] So, prior to coming to Australia, in [home country], she was seeing her doctors. And they said, 'you might have to, because of these problems, you might have to have surgery'. So, because of that, she said, 'No, I don't want to do that', and then she would rather die than … so she said she didn't want to do that, so she didn't do that" (Fjolla, lines 78-82)*

Fjolla was brave enough to tell this practitioner that she did not want to take the drastic action of surgery that had been directed. Her choice stemmed from a lack of trust or faith that her needs were not being listened to by the practitioner. Instead, now that Fjolla is in Australia, she has sought care for the same condition, hoping for a different diagnosis and treatment plan that better aligns with her needs.

Clients also experienced mixed messages when seeking care in Australia. Tetyana, for example, shared an experience she had before starting in the Branching Out program, of following instructions without clear direction,

> *"[client] During that time, my condition was really worse, and I was attending the program at [name] hospital…my physio at the hospital, they suggested me to only, not to use the sling, because in this condition your arms will get immobile in the same position.*

[researcher] So, why were you wearing the sling?

[client] Because I was unable to move my [..]. Because I was feeling a lot of pain when I was using my arm.

[researcher] So, you just put it in a sling yourself – because it made it feel better?

[client] Yes because before, I think, last year, one day I was crying with the pain, I went to the hospital emergency. They put a sling on my arm, then I was used to using every day because people don't know when I suffer and when I manage on train or bus, or three, four times the people they hit me, and that's the reason I started to wear the sling, and then this was okay, 'until you feel better you can'. People they can know you have a problem in the shoulder, because this is an internal injury." (Tetyana, lines 60-72)

Tetyana felt she was being given conflicting information. Despite the apparent benefits of using a sling, she learned that wearing the sling in this way could cause her arm to become immobile. Conflicting information can result in confusion and, therefore, mistrust in the healthcare system.

Communication barriers were common within the client experience. Many participants could not speak, read, or write in English, and some were not literate in their native language.

Fjolla had received little education in her own country and was not literate in her language of origin or English. She struggled in the community health centre's busy reception area, where clients were called by their number,

"[client/interpreter] And, as she never been to any college or study in the school system, for herself, sometimes hard to recognise number six in line" (Fjolla line 22-24)

Being illiterate is a barrier to many things in life. It is especially challenging when it is a barrier to gaining access to healthcare or understanding practitioners' directions. Fjolla has been taking English classes since coming to Australia, which she found helpful,

"[client/interpreter] Now she is finding she can recognise the numbers from one to twenty – slowly – and she can write her name, and things like that, helping her quite a lot. She finds the government quite helpful; people are quite helpful" (Fjolla, lines 31-35)

These small literacy steps help Fjolla overcome barriers to gaining access to healthcare and are vital in building trust with the healthcare system. The English classes are provided by the government, which Fjolla acknowledges as helping her, and then extends this to other people being helpful. It is expected that this positive attitude may extend to her practitioners in the future.

Efua was not literate in English but was able to read and write in his language of origin,

"[client/interpreter] If it was easy to follow, yes, the way she was drawing was very easy to follow. Also, she suggested me to write down in my own language with each drawing to make sure that I can remember it later what is each one" (Efua, lines 87-91)

The interprofessional team's use of drawings (e.g., drawings of exercises to take home), supplemented by explanations in the client's language, enabled the language barrier to be overcome to provide safe care.

While not all clients in the interprofessional practice approach felt that their condition improved, many spoke of an appreciation for holistic care. For example, when asked what he liked or did not like about the program, Mahavir, who did not find the program helpful overall, was nonetheless appreciative,

> *[client/interpreter] There is no such thing like, I don't like a particular part, there is no such thing, and what they did was for my benefit which I understood and appreciate" (Mahavir, lines 65-68)*

Mahavir was grateful for the service he received from the practitioners, perhaps reluctant to offer any criticism. His way of holding back from speaking about negative aspects of the program may be due to a fear of consequence or genuine gratitude for any help to reduce isolation.

6.2 Opening up to others

The second major theme to emerge from the client interviews provided more in-depth insights into how they felt about being part of the program's therapeutic sessions and opening up in a team setting. Two subthemes emerged within this major theme explored in the next section, *'Learning to trust a team'*, and *'Learning that it's all connected'*.

6.2.1 Learning to trust a team

The Branching Out program, with its interprofessional approach, was a new experience for all the clients. In particular, none of the clients had previously been in a clinical session where two practitioners from different professions were in the session with them at the same time. This subtheme explores how the clients felt about being part of this care setting. These perceptions are discussed at two different time points, how the clients felt before being part of the initial joint therapeutic sessions and their experience of interacting with multiple practitioners during these sessions and throughout the remainder of the sessions during the interprofessional program.

During the intake interviews, the clients were advised that the initial session would be longer than usual, and two practitioners would be present (most usually a counsellor and a physiotherapist). Most of the clients agreed to participate even though it was a new experience for them, as noted by Anneli when she discussed the first session and how she felt about this,

> *"[client] Yeah, the first time, it's quite long because with two sets to share, I have to talk a lot…I had to talk to another one, and then talk to another one. It's okay with me. I feel good because I don't feel stressed and all this, which is good because they were there to help me. (…) Yeah, because normally I don't know this, but this was the first time they let me know that 'now you have one room and two ladies, one physio and one with counselling. Is it okay?', and I said that's fine" (Anneli, lines 51-57)*

Anneli was open to this new experience. She did not show any anxiety towards attending a session with two practitioners, and while the ninety-minute length of the session was long, it was not a burden for her.

Despite the information provided in the intake sessions (which were over the phone before the initial joint therapeutic sessions), not all clients were aware that they would be in a session with two practitioners. Mahavir was one who found the two practitioners to be a surprise,

> *"[client/interpreter] I was not expecting two people in the session. I had some health issues, and the doctor advised me to come over here, and he made the appointment, and I came over here. (…) Only at the time of the session, I came to know that there was a counsellor and a physiotherapist. After I explained of my problems, I felt I talked about my problems, and I felt much lighter" (Mahavir, lines 9-20)*

Mahavir did not understand the information provided in the intake interview or perhaps did not feel the need to understand the information provided as he was attending under his physician's directive. This mismatch in expectation of the initial session did not seem to have caused Mahavir any additional anxiety.

Some clients – like Arya – preferred to have more than one practitioner in the session,

> *"[client/interpreter] I feel more confident and comfortable to talk when there are more people" (Arya, line 108)*

Having a witness to his words or just feeling more comfortable in a team social setting may be important for Arya's experience of joint therapeutic sessions.

Anneli also finds the sessions with two practitioners to be beneficial because she can see them both taking note of her concerns,

> *"[client] I think that is the combined thing. I think that is very good, because I like it, because both of them were, yeah. And I said about my pain, and they said they might be recorded it down, and my counsellor read it like what I am saying, and my counsellor also record down what I am saying because I see the both of them together, it's good, I see, and I like it" (Anneli, lines 36-39)*

Anneli became aware of the communication between the practitioners and between the practitioners and herself. She noted that they are recording her needs and reading this back to her. Anneli commented that she found this comforting, as it gave her more confidence and allowed her to build trust with the practitioners.

Mahavir was another client who felt the initial joint therapeutic session was helpful,

> *"[client/interpreter] I remember spending a longer time, but that is not an issue at all. Apart from asking questions, they have also allowed me to explain, on my own, what happened to me and what my problems are (…) In that session, I was able to tell all my problems, and at that, I felt a significant relief after telling them the problems. It was helpful in that way" (Mahavir, lines 41-45)*

Mahavir reflects on telling his story in his own words, taking his time to do so. The relief he feels in retelling the details of his past life provided a sense of catharsis.

Some clients noted that they had opened up for the first time in the initial joint therapeutic session to tell their story. Tetyana explained what it was like to do this with the physiotherapist and counsellor in the same room together the first time,

> *"[client] It was very, very, sad that first day. I was very sad, and I cried a lot in front of my counsellor and physio because I was in pain. Emotionally I was so upset. I was in depression, but lots of things in my life, in my heart and my chest. I was so pressurised, so I wanted to tell them my whole story, my counsellor, and the physio, plus my condition - how it happened and all that. It was sad very sad. (…) It made me very strong, emotionally, and physically they made me strong. The physio and my counsellor yeah .. they had done a great job.(…) Even as I was unable to speak in the first meeting with the counsellor and the physio on the first day I was, all I wanted to do was be myself very quiet. Then when they start asking questions, it was painful" (Tetyana, lines 267-282)*

Tetyana did not intend to tell the practitioners her complete story that day. She attended the session, wanting to keep to herself and listen to the practitioners. Instead, she found that they provided her with the confidence and space to open up to them. Once she started telling her story, Tetyana did not want to stop. Encounters like Tetyana's are charged with emotion. She was suddenly distraught with the memories she was revealing to the practitioners. Some clients, like Tetyana, brought other emotions to the forefront, such as embarrassment and sadness, as they revealed past details. The practitioners needed to be prepared for this emotional charge. They focused on the essential issues and encouraged the client to continue their story through the tears.

Arya stated he was comfortable with the joint therapeutic sessions and felt that he understood why different modalities were included during the program. However, he shows confusion when the physiotherapist is no longer part of his care plan,

> *"[client/interpreter] Yes, they told me, they told me it was a service which has different things like physio, counselling, hydrotherapy, massage and everything, and for the first few sessions, they were together and then I had each service separately. (…) The first session was good because of how long I am suffering from being alone all the time. Was good they were together and the first two sessions they were together, but then the physio just phased out, or ... wasn't there anymore apparently" (Arya, lines 96-99)*

Arya appears to understand the program's approach. Nevertheless, he feels the change to his care plan to discontinue the physiotherapist's involvement appears not to have been discussed with him,

> *"[client/interpreter] They physio said my job is done with you, and we don't have any more sessions, and the counsellor said we have six sessions and then that's all we have, and then they referred me to [external service] to continue getting the service from [external service] – so …. Because I don't have a Medicare[5] anymore, so they referred me to [external service], and the [external service] they don't need Medicare apparently, and they have the same services, like counselling and everything .. so .. my counsellor referred me there. …. I am happy with my psychologist or counsellor, but I'm not happy with the physio at all. I am still in a lot of pain, and he didn't care. I told him a lot, and he didn't do anything (…) they didn't do anything;*

[5] Medicare is Australia's universal health insurance scheme.

it was just talking, like a meeting. It doesn't help the pain because before, during the physio sessions, I used to get some treatments. But they didn't apply anything; they just talked.. like the physio just talked and talking doesn't help. And because I have tight muscles I have to get a machine (interpreter says – I don't know what he means), but I told him, and he said no you just have to do the exercises I told you at home" (Arya, lines 122-142)

From this second extract, it is clear that Arya expected that the physiotherapy session would be a hands-on session with treatment. While this type of physiotherapy session is common, the service available from the cohealth community health centre did not include hands-on treatment for Arya's condition. This mismatch in expectation was significant in terms of Arya's care experience for his condition and added to his confusion of the interprofessional approach. Arya felt he had provided the physiotherapist with information about his needs but had not received anything of value in return. Because of this mismatch in expectation, Arya did not understand why he was not given the treatment he expected, so he remained disappointed with the physiotherapist. The referral to the outside service, a commercial centre[6] for physiotherapy, would provide the type of hands-on care Arya feels will help his condition. In this way, the mismatch in expectation is realigned, but Arya may continue to negatively associate this experience with the healthcare provided by the Branching Out program.

One of the communication mechanisms employed by the practitioners during joint therapeutic sessions, was having one practitioner ask a question of the other

[6] The client's eligibility for Medicare is not known. The external service agreed to provide him with the service he was requesting.

practitioner to help elucidate information for the client, commonly known as Socratic questioning. Clients had noticed the deliberate activity of practitioner question technique, as noted by Arya, when describing the actions of the two health professions,

> *"[client/interpreter] Ah, the other person was sitting and listening, and sometimes they would try together about the pain, for example, 'he has pain in his leg. What should we do to help that?' But most of the times, one of them was speaking, and the other was listening. Sometimes they would ask each other questions, for example, the counsellor, she had a problem or a question she would ask the physio so it would clear, and then again continue, but sometimes they would ask each other questions" (Arya, lines 53-63)*

Arya found this questioning by the '*listening*' practitioner to be helpful and noted that sometimes this questioning was directed at understanding his condition. At other times, he felt one practitioner was seeking information for their use from the other practitioner. Arya was already disappointed with the care he was provided, so this association with one practitioner learning from another may create a distrust of the practitioner's expert knowledge, further diminishing the therapeutic relationship.

Fjolla also experienced the practitioners asking questions of each other in the joint therapeutic sessions,

> *"[client/interpreter] So, it was pretty much an average of half-half, in a way, in that they ask her questions, and she explains them. If only one were asking questions, then it is hard to tell everything, so it is good that both*

were half-half. (…) So, it was in a sequence. So that one person asks her a question, and then she answers, and then the other person asks her a question and then she answers.

They do have questions of each other .. yes, they did ask questions of each other's and also, in a way, they did help her quite a lot. She was really happy; it went well the whole time. (…) Yes, she felt they were all very good, the questions they were asking were there to help her in a way, so she was really happy and very pleased about it" (Fjolla, lines 110-136)

While the responses Fjolla provided concerning the practitioners asking questions of each other seemed to paint a picture of a helpful episode, the last comment draws our intention back to several of the clients having reported gratitude for the care provided.

However, even when clients did not understand why the practitioners asked each other questions, they reminded us why it is essential for them. Basia provided an example,

"[client/interpreter] Ahh, I am okay with the time [length of the session] because sometimes I don't know how to ask them the questions, because I am not used to asking those questions – whatever the time it is okay with me. (…) Sometimes I hope I will ask that question, but I hope they will help me, and they really help me with this pain" (Basia, lines 163-178)

Basia explains that she is not used to asking questions of practitioners. It is likely difficult for her to phrase her question the way she wants and have the courage to

ask the question while in the session. Basia does not mind how long the session may seem, and she was happy to listen and learn from both the practitioners.

The initial joint therapeutic sessions were followed by single sessions with each of the practitioners as part of the program. For many of the clients, the single sessions were held on the same day as back-to-back sessions. These sessions allowed the practitioner to catch up with the client, in-between the single sessions to share notes and schedule ongoing sessions together. The joint sessions between single session appointments became valuable to clients. Time could be saved travelling, and one interpreter could be engaged as a single booking.

Mahavir appreciated this collective time between single sessions, as it also served as convenient for scheduling appointments, allowing him to feel his needs were being met,

> *"[client/interpreter] They have always consulted me before scheduling the appointment, and so all help has been taken, so it was positive and no problem" (Mahavir, lines 131-133)*

One of the benefits of the back-to-back single sessions was the practitioners' ability to talk together in-between sessions. There was a benefit for the client also, as they could understand the type of information shared between the practitioners. Efua explains her experience of this taking place,

> *"[client/interpreter] Yes, I knew that because every session at the end of the session I could see that [practitioner-1] was explaining to [practitioner-2] what we went through and all the details and everything. …. At the end of the session [practitioner-1] would go to the other room where the computer*

is to give me the next appointment and [practitioner-2] was there, and he was explaining to [practitioner-1] what we went through and all the details. He was trying to work around my timings, because my preference was from 12-1 or 2 to work with [practitioner-2] first and then to speak with [practitioner-1] ... and he was always accommodating" (Efua, lines 42-60)

Efua appreciates the practitioners' accommodating her scheduling preferences and ensuring that she understands what information they share. The joint sessions are another opportunity for clarifying care planning with the client. In this following extract, Efua also explains why she likes to have the two appointments one after the other,

"[client/interpreter] I reckon it would be better, more beneficial, if we were doing it in the same order, same time, same day because that would be very good, because as soon as you do this, then you have the other person and speak to the other person, if there was any question then it's good timing to ask the question from the other person, so it would be better to do it at the same time" (Efua, lines 65-73)

Efua has learned to maximise the time she has with the two practitioners and has also become comfortable asking one practitioner's questions to help her tease out any information she needs that the other practitioner did not provide.

The back-to-back sessions that Golzar attended had another bonus for him as sometimes, the practitioners might drop in for a quick joint therapeutic session,

[client/interpreter] The plan was different; each one has his own, but sometimes the physio comes when I have the other one, and if she needs

something, she will discuss it, and that's what they manage (Golzar, lines 32-37)

The extract from Golzar showcases how relaxed and informal the practitioners and clients had become with each other. Golzar was quite happy for one practitioner to drop in on another practitioner's session to discuss something with him if they needed to. It is not clear from this extract if the practitioners had organised this beforehand or not. However, they likely kept in touch with each other between sessions with Golzar and had a joint calendar for signalling when appointments were made. However, while this arrangement was comfortable for Golzar, it may not have been appropriate for other clients (no relevant information is available within this study).

6.2.2 Learning that it's all connected

One of the critical factors for building trust in the interprofessional team was the practitioners' ability to reassure the clients that their clinical details would remain confidential within the team. Mahavir responds to this question that was typical of most of the clients,

"[client/interpreter] I don't have any friends, I don't share my problems with anybody else, but when I came over here, they were sort of suggested that I should tell the details, and most importantly, they said that all the information I will tell them would remain private and confidential and that was the reason I was able to explain. I was able to tell more of the in detail" (Mahavir, lines 49-52)

Mahavir had not been able to open up to practitioners in Australia before the Branching Out program. Once he understood that his information would remain confidential within the team, he found he could share more.

Tetyana was one of the clients who had been able to make friends in Australia, but before the Branching Out program had not been able to discuss her issues with anyone outside,

> *"[client] Yes, I share my problems, I share my things with them, my friends yes. That is helping, yes*
>
> *[researcher] Did you do that before; did you share before?*
>
> *[client] No, before, no, because I came here, I was totally quiet and all the time. I didn't talk to anyone" (Tetyana, lines 111-115)*

The Branching Out program has helped Tetyana to open up more to friends. She has more confidence in herself and can trust those close to her with her issues without fear. Gaining confidence from the relational support within the interprofessional approach in this service helped Tetyana in other areas of her life.

Many clients provided information relating to problems in their family or social life where those close to them had not believed the suffering they were going through was due to their chronic pain condition. Fjolla was one of these clients who had more confidence with her family after validation from the Branching Out practitioners,

> *“[client/interpreter] It helped her quite immensely in a way. But it was like being a teacher and giving some pictures with some exercise, at home it*

makes some sense because there is someone telling her how to do, that's how good it is for her. And also, having someone validating that then it's those things that are making her feel better and doing it helps her. So, before that, before all of this, when it came down to herself, she found it really hard doing everything. People outside would talk about her, saying she is mentally disturbed, she's gone down, she's not up. She can hear all those things. But she tries to forget all those things. And then when it happens amongst family members - I mean, okay, your kids your husband say okay you have lost your mind or something. And it was really hard. But then having someone behind to validate that those things are good, don't give up. That helped her quite a lot, yes. Before that, she was saying, all she could do was just cry" (Fjolla, lines 141-153)

Just as Tetyana had learned to open up to friends without fear, Fjolla also learned that she could talk about her illness with family without fear of being dismissed. The validation and relational support she received from the interprofessional practice approach may have helped repair her confidence in herself.

Many clients noted that the family was an influential social need and support for them. So, treatment options offered needed to be appropriate to ensure they could continue to meet their responsibility for immediate family and children. For Anneli, the medication she was receiving for her chronic pain was so debilitating that she was unable to care for her children, leaving her with great sadness,

"[client] Yes, and then I said to him, you gave me those ones, and who's going to look after my kids? That's a strong medication. If I drink (the

medication), I sleep all day. And I can't drive a car too because it makes me drowsy. Who's going to feed my small ones? You should have led me to the physio, and they going to help me and give me idea and I can manage my pain. But, he didn't do that, he just give me the medication. But I go to Cohealth and they help me. They give me the word and I'm managing and I'm doing exercise. And now I am free. I don't need to take the medication. Doctor said, 'Oh sorry, and you asked me to refer you to a physio' – 'No it's too late, it's too late', I say, 'I already got someone, I am okay', I said. Doctor was so sad and that, and doctor say 'Sorry', will say that – well you asked me, so I said that" (Anneli, lines 225-235)

Anneli had me laughing with her. She recounted this story about going back to the physician who prescribed medication for her condition and telling him she did not need his medication anymore. Anneli appeared strong in that moment of telling her story; she was proud of her stance with the physician and proud of herself. She had conquered her pain with self-management techniques learned through the Branching Out program, and she had done this without the physician directing her to do so. This moment is decisive for Anneli, as the physician is an authoritative figure, and she was able to show him that she held a positive agency in her life decisions. Providing clients with the support to develop autonomy in this way was one of the interprofessional program's key goals.

Another of the prime goals for utilising an interprofessional practice approach was to help clients understand the connection between the mind and body regarding pain management. For many clients, this was a new learning experience. Efua expands on what she has learnt,

"[researcher] And did they explain to you about how your stress and your pain are connected?

[client/interpreter] Yes, he did explain how they are interconnected and how one can affect the other one, for instance, the stress can cause a lot of tension in the body and the muscles become tense sometimes and how it can lead into physical pain and also to the extent of having osteoporosis and those kind of physical problems. And also, then he explained how they are all the by-products of a busy mind and when someone's got too much on their plate

[researcher] And did that help you – was that something that was helpful to understand that connection?

[client/interpreter] Absolutely, yes" (Efua, lines 103-110)

In this extract, it is obvious that many of the words and phrases the practitioners used to help Efua's understand the message of the therapeutic session were retained in the form they would have been used in the sessions. The phrase used by Efua, *'having too much on your plate*,' is an old English expression[7] (Brewer's dictionary of phrase and fable, 1984). While *'by-products of a busy mind'* is a more recent addition to western culture[8] , most notably used in mindfulness and relaxation programs (Anxiety and Depression Association of America, 2019). By repeating back these phrases, we cannot be certain that Efua has retained the

[7] To have a lot of/enough/too many things to worry about or deal with (online Macmillan Dictionary 2020)
[8] Busy mind is a catchall term used to include anything that pulls you away from showing up fully for your life at this moment (Bradley 2018)

meaning intended. However, Efua has started to use these phrases, a step towards integrating them into her worldview.

Tetyana also provided feedback on learning about a mind and body connection during the program when she discussed what the physiotherapist told her about the pain in her arm and leg,

> *"[client] Yes, she told me the same thing. So, when emotions come in your mind it upsets your pain increase, and then she told me the exercise and she draw some pictures on paper, yes (...) so, it's all connected, yes. The emotions and the pain. (…) That was worse, really worse. 99% I felt most of them, I felt didn't, pain in my body yes, stay with pain. Even the exercise didn't help me before to see physio. I was used to perhaps a little bit of exercise at home, but it wasn't helping, .. Yes, yeah .. and I noticed that whenever I get more emotional and I cried I feel the pain in this part, and this part, but after exercising when I get busy, some mediation, yeah, some exercise I feel okay" (Tetyana, lines 141-163)*

In this extract, Tetyana demonstrates she has understood the relationship between the mind and body and can articulate this in a meaningful way. Tetyana started to use this new information to help manage her chronic pain condition, which is an essential step in self-management progress.

Another critical factor in determining client progress was their increase in confidence in being able to engage with self-management techniques, which was a new experience for most. In this extract from Efua, she discloses how her confidence has improved to the extent that she can now make decisions for herself,

"[client/interpreter] Yes, one of the things I can tell you, one of the important ones is I used to think the others should make decisions for me, and I wasn't independent at all, which wasn't the best feeling. But right now, I know that I am independent and can make decisions for myself" (Efua, lines 111-119)

As the interpreter spoke these words, Efua leant over and touched me on the arm, looking straight at me and nodding. It was easy to interpret the meaning of this gesture. It was a little cheeky, as if she had just got away with doing something she has always wanted to do but previously did not have the confidence to take the chance.

6.3 Ready to move on

The third major theme to emerge from the client interviews concerned how the clients felt at the end of their time in the Branching Out program. Some were excited to tell their health journey; how they now feel better and cope better with their chronic pain. However, not all clients felt they met their goals. These views are explored in more detail in the following subthemes, *'Owning the pain'* and *'Wasting my time'*.

6.3.1 Owning the pain

The clients '*graduated*' from the Branching Out program when they felt confident they could use self-management strategies for their ongoing pain. For some, graduation meant they could cope with managing their pain within their life situations. Anneli was one of these clients,

"[client] Yes, yes, that's true, well I say now doctors they need to refer to some people like this, and they can help .. because I am getting help from their words. Cohealth didn't give me any medication, just the word. Tell me how to do this and manage my pain. So, now I'm okay.

… [client] Yeah, I really like it. Yeah. And I think the doctors they should do that. Tell them to go to the exercise place, and then after, when people are doing that, then they should give some medication." (Anneli, lines 241-247)

Anneli is full of confidence with her new ability to self-manage her pain without medication. She suggests others should also be referred to the program or learn to use exercise before being given medication for their pain.

During the time in the program, Mahavir developed a deep trust and respect with one of his practitioners, as can be seen when I asked if any part of the program made him feel uncomfortable,

"[client/interpreter] When I was sort of meriting my experience first time, I was feeling a bit uncomfortable, not sure, but afterwards, I understand that they are asking the details for my benefit. So, that I was able to overcome that for the merit and that when I went to the [external clinic], I think the counsellor was a lady, is that right, I more considered her as my mother. In that exalted position, that your mother cared for the son. And in that frame of mind, I mentioned that the problems that I had, and the counsellor was able to help. (interpreter: That is often one of the cultural aspects of the community - even though he didn't mention it, I am just giving you an explanation)" (Mahavir, lines 69-76)

Mahavir's care team included sessions with an affiliated counsellor at an external clinic. His feelings towards this counsellor were of the greatest respect. In his language, he denotes this person to be his mother, which the interpreter explains is considered naming someone into the highest honour.

Efua graduated from the program but felt she was not coping as well as she hoped. In this extract, she explains how she attended a session with her physician and asked to be referred back to the program,

> *"[client/interpreter] Not only I told the doctor but also these two people that helped me they also left a message on my record so the doctor could follow – what I told the doctor was that as long as I was seeing these people, I was feeling better, but while I have not been seeing them again then everything is coming back .. that's what he wrote down and referred me back to the program. I felt so bad the other week that my doctor prescribed me some medications meanwhile until [Branching Out practitioner] comes back from holiday" (Efua, lines 141-148)*

Efua has learned that her physician and the practitioners at the Branching Out program communicate with each other and used this knowledge to ask her physician to refer her back to the program. Efua would rather wait for her practitioner of choice to return from holiday than see another practitioner, so she accepts a prescription of medication to help keep her pain at acceptable levels until she can schedule an appointment. This level of connection with her original practitioner in the Branching Out program demonstrates the level of trust Efua has developed in this practitioner, which is manifesting as a dependency. This dependency is likely to be a connection to the practitioner, which remains from an

early treatment phase, that was not resolved during her first round of sessions in the program.

Some clients noted improvements in their ability to cope with psychological factors, along with their pain management,

> *"[client] My change is since I involved with this program, I used to, you know I used to have stress, and I have a anger, my anger used to come, worried, and I feel frustrated, and all this. Since I come to this counselling, it slowly, slowly, goes down. Since I didn't really solve my problem and all my angers and everything, I keep it. To know it is just killing me. And so, I just feel this anger is just coming out really quick, but since I come here, they talk to me, and I listen .. okay .. I didn't know .. just relax and quickly, slowly, slowly, slowly .. so now I feel good now yeah" (Anneli, lines 152-157)*

Anneli has learnt techniques to help her self-manage her anxiety, stress, and anger. She has listened to the practitioners and understood that she could not hold on to her anger and relax and breathe when these episodes happen. In this way, Anneli has demonstrated her ability to have a strong sense of control over her emotions that is empowering and life-changing.

6.3.2 Wasting my time

This second subtheme examines the comments made by clients who did not feel the program meet their expectation. Instead of discussing their struggle and

frustration with the Branching Out program, these clients did not own their pain so were not able to move forward in their health journey.

Saam felt the sessions were not helpful due to healthcare beliefs he was not able to let go of,

> *"[client/interpreter] Yeah, so I haven't noticed, so when I was in the counsellor sessions, so that was alright, or when I was somewhere else, when I was in the massage or with the physio .. it was okay for a while, but honestly I don't know, it hasn't worked on my body, and after the surgery, the doctor said you should have recovered in 12 months, but now it's like 28 months and some suffering, so the doctor said that if you haven't recovered in 12 months, it's unlikely that you will recover in the future and not something we could offer, so we don't have any further treatments to offer you" (Saam lines 30-36)*

A physician told Saam that he would never recover from his chronic pain condition. As the physician is an authoritative figure, Saam may have taken the physicians advice as a truth that cannot be changed. He has, however, attended the Branching Out program with the hope that they would be able to provide him with something that the physician could not do. However, Saam notes he did not feel the sessions held any positive effect for him,

> *"[client/interpreter] If I am speaking to them, like if I am speaking to the counsellor, it is okay when I am in the session, but as soon as I walk away, I am still the same person, and all the symptoms are the same" (Saam, lines 104-105)*

Saam is listening to the counsellor during the session, and this is providing some positive impact demonstrating his ability to accommodate this information within the session. In his earlier extract, he also found some relief with physiotherapy and massage, but he does not integrate this information into his daily life. The physician's words have a more powerful effect on him than his own body telling him that he feels relief while in the Branching Out therapy sessions. However, Saam was not able to trust these feelings. Saam's ability to assimilate the messages from the Branching Out practitioners were not evident; the way he is making sense of his condition remains with the medical model. For Saam, only the absence of pain would meet his idea of returning to a healthy state.

Arya is another client who did not feel the program was worthwhile attending,

> *"[client/interpreter] They physio wasn't much of a help, but the counselling was not bad – better than the physio …The physio was just talking and talking doesn't help the pain; it's not helpful to pain. And the counsellor was talking as well, but because my problems were so severe and I had a lot of problems, so that wasn't much of a help" (Arya, lines 14-28)*

Arya is disappointed that the practitioners could not provide active treatment that may have helped his condition. Instead, he is frustrated that they only talked to him. In this following extract, Arya reveals that he has tried many forms of treatment inside and outside the Branching Out program, and nothing seems to help,

> *"[client/interpreter] No – they told me to exercise every day, go for a walk, I do that – I did that – I am seeing a dietician to lose some weight so that it would help the pain. I did what everyone told me, but it didn't help. It is*

getting worse. It has inflammation, and I had a lot of pain last night, and I couldn't sleep. Nothing helped the pain, and I did whatever they told me, I even went to the hospital, I had surgery, I did all the exercises the doctor told me, but it is just getting worse, nothing is helping" (Arya, lines 158-171)

Arya's frustration with the treatments he has tried is getting worse. He is getting desperate with the pain. The Branching Out team has referred him to additional counselling sessions to learn to manage his condition, but this referral does not meet Arya's physical treatment expectations. The Branching Out program practitioners, along with other practitioners Arya has consulted, have deepened his resentment of treatment designed to support his self-management, firming his resolve that mind and body are separate.

Other clients also felt the program had not helped them. Their pain had not gone away at all, being an unrealistic expectation of chronic pain conditions, or that the pain had returned as soon as the sessions were over. One client felt the home exercises provided during the sessions were causing them more pain, so they abandoned their exercise schedule as soon as they completed the program, showing that this client had accommodated the information during the session but could not assimilate this information into their day-to-day life.

6.4 Summary of this chapter

This chapter provided the findings that emerged from the client's interview transcripts and the researcher's notes during the interviews. Three major themes emerged from the client interviews. The first major theme of *'The person beyond the pain'* aligned to the clients' preconceptions of healthcare providers derived

from their experience in their home country or within Australia and of the holistic needs they brought with them to be healed.

The second major theme, *'Opening up to others'* emerged from the client's experience of the interprofessional practice approach. Many of the ways of interacting between the practitioners and clients in this program were new for the clients. Some felt at ease in these new environments, while others felt a mismatch in their expectations of what the interprofessional practice approach would provide. Most clients commented on their appreciation for the statements of confidentiality provided by the practitioners. It made them feel safe to provide information to the practitioners and share this information within the team. Many of the clients felt confident after their involvement in the interprofessional practice approach sessions. This confidence was extended to their home and family and discussing issues with friends they had not been able to do before.

Important information emerged from the client's impressions of their outcomes after being part of the sessions which utilised an interprofessional practice approach, impressions encapsulated in the third major theme, *'Ready to move on'*. Many clients were happy, healthy, and confident in their interviews and discussed their new confidence and ability to self-manage their chronic pain condition. Some clients felt the program would have helped them more if the joint therapeutic sessions were shorter (less tiring) or by providing more active treatment modalities within the program. However, a couple of clients did not feel the program provided them with the expected outcomes for their chronic pain condition.

Chapter Seven: Discussion

Analysis and interpretation of the findings from this research were reported over the two previous chapters. In Chapter Five, the practitioner data analysis and interpretation across cases were presented. Chapter Six presented the client data analysis and interpretation across cases. The overarching research question for this thesis, posed in Chapter One, was 'How do practitioners and clients make sense of working together in an interprofessional team?' This research question is explored through this discussion chapter; however, while practitioners provided detailed descriptions of their experience, the clients were less able to give detailed accounts due to language barriers and limited prior experience of the healthcare setting.

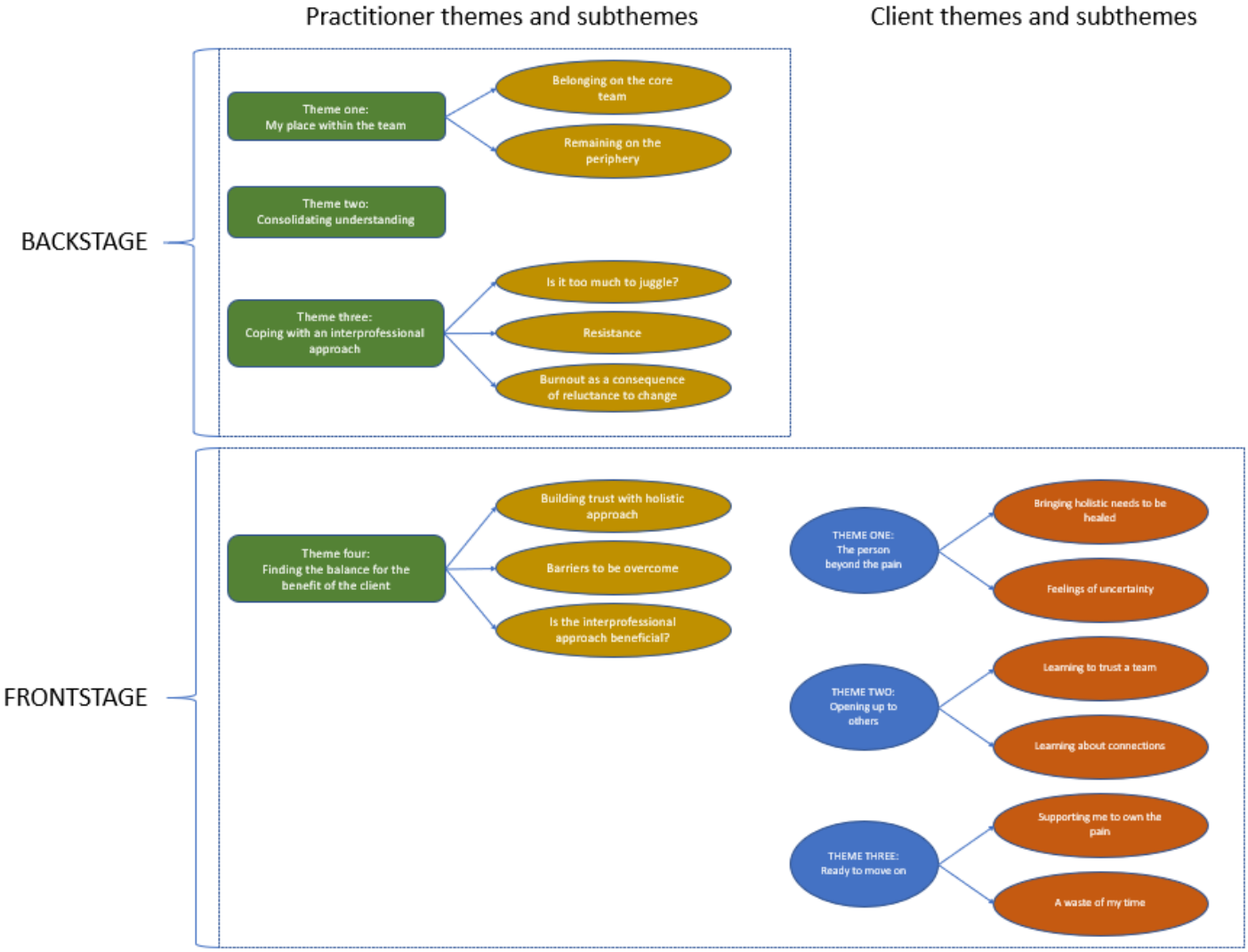
For this reason, this discussion chapter is focused on exploring the practitioners' experience and integrates the clients' experience where this is possible. Therefore, this discussion chapter is structured to follow the same themes that emerged from the practitioner findings. Within each of the major themes, this discussion explores the relevant theory and extant literature to understand the researching findings on a deeper level.

Careful consideration of practitioner themes revealed that practitioners experienced two distinct ways of working within the interprofessional practice approach, which relates well to the 'backstage' and 'frontstage' concepts described by Lewin and Reeves (2011) The backstage component refers to the practitioner's experience of interprofessional practice outside of direct client interaction, which may include meetings before clinical sessions, team meetings, and their preparation for interprofessional practice. In contrast, the frontstage component describes the experience with peers within clinical sessions and meetings where the client interacts with the practitioners. This framework will be used to structure this discussion into two parts; Part One explores the backstage activities of this study, while Part Two explores the frontstage activities.

PART ONE: Backstage – the experience of practitioners in the team without direct interaction with clients

The practitioner and client themes and subthemes are grouped into backstage and frontstage experiences in Figure 7.1.

Figure 7.1 Major themes and subthemes grouped by backstage and frontstage experience



This discussion follows the practitioner's journey of joining the interprofessional team, learning to belong or enacting professional boundaries, and the importance of interprofessional leadership in guiding the team.

7.1.1 Joining the interprofessional team

The experience of the practitioners in this study revealed that they felt the values of the cohealth community health setting (cohealth 2020) complemented the values of an interprofessional practice approach as established by Barr and Low (2012). These interlocking values provided a robust foundation for the clinical program and, subsequently, interprofessional practice. For example, the cohealth value of *'inquiry and innovation'* complemented the creation of this new program, which was designed to utilise an interprofessional approach to meet the needs of this complex client group more efficiently. The cohealth value of '*respect*' provided a clear guide for team members to treat others with dignity and mutual regard, aligning with the interprofessional value of respect for individuality within and between professions. Also, the cohealth value of *'social equity'* (being committed to fairness and equality, making sure rights are foremost in thoughts and actions, and making sure no one is left behind) closely aligns with the interprofessional value of focusing on the needs of individuals, families and communities.

These complementary values, nested in the community health setting and those of an interprofessional practice approach, helped the practitioners feel existing clinical processes supported and supplemented with this new approach. Practitioners felt this new approach differed from their usual care processes in some significant ways, providing an experience different from usual care. Founding practitioners could incorporate this new framework into their existing practice adding a new element of team identity to their day-to-day activities. Team identity was widened to incorporate new members as they joined. The success of these strategies helped provide a foundation for a sense of belonging within the

interprofessional team for some practitioners. However, not all practitioners developed a sense of belonging in the same way.

One of the significant findings was that the team's expansion with new practitioners joining the team, separated practitioners into considering team members to be core or peripheral to the team. Those who pronounced this distinction felt this way despite also acknowledging that peripheral members were engaged with the values-driven approach of being interprofessional concerning their clinical care with clients (frontstage activities), suggesting other factors were driving their chagrin. The categorisation into core and peripheral members created a demarcation in the team, which could lead to the team being further fragmented, challenging the long-term sustainability of the interprofessional approach.

The core team members distinguished themselves from the peripheral members by their immersion in the interprofessional program. In contrast, the peripheral members lacked attendance during backstage interprofessional activities such as interprofessional team meetings. This differentiation between practitioners who wholeheartedly embraced the interprofessional approach and those that did not aligns with the description of '*dual identifies'* provided by Khalili et al. (2013). The development of dual identities is an aim of interprofessional socialisation, which helps practitioners to develop an effective and meaningful interprofessional experience while still maintaining their profession-specific roles (Arndt et al. 2009; Baker et al. 2011; Cameron 2011). The need for interprofessional socialisation of this nature emerged from studies that demonstrated that practitioners often developed an orientation towards their own profession, in-group favouritism, and an out-group discriminatory bias which lead to distrust towards those outside of

their profession (Baker et al. 2011; Cameron 2011; Lloyd et al. 2011). This in-group and out-group behaviour is similar to the core and peripheral behaviour acknowledged in this study. Some practitioners showed a bias towards working in their usual care processes (within their own profession) compared to working within the interprofessional team (which they viewed as an out-group).

Alignment of a practitioner's values and those of an interprofessional approach is one of the first stages of interprofessional socialisation (Hamilton 2011). This process requires active learning and recognition of the interconnectivity and complementary roles and responsibilities of other professions, which help practitioners develop an interprofessional identity (Khalili et al. 2013). In this study, the alignment of the practitioner's values, those of the community health centre, and the interprofessional approach provided a strong foundation for developing a sense of belonging to the interprofessional team. Adamson et al. (2018) reported that practitioners felt a sense of belonging when they held respect for the individual differences of others which aligned to their own. In this study, the practitioners felt that the community health centre's values and working conditions (low pay and long hours of work) attracted similar personalities to working in this care setting.

Some practitioners in this study noted respect for others in the interprofessional team for their choice to work in community health. These practitioners inferred that making these choices in working conditions helped align their thinking, thus enhancing their feeling of belonging in the interprofessional team. In alignment with this finding, other researchers have found that practitioners' differing personalities, values, and attitudes could be barriers to a successful collaboration (Baldwin 2011; San Martin-Rodriguez et al. 2005). Adamson et al. (2018) also

reported that understanding personality differences was crucial for understanding roles and responsibilities in interprofessional teams.

If practitioners expected colleagues to respond in the same way as themselves to the interprofessional practice approach because of their shared choice to work in community health, it might have been a surprise to find that not everyone prioritised the interprofessional activities over their usual work practices. Therefore, this feeling of their colleagues being different by way of making different choices may have led these practitioners to feel that the others did not belong in the interprofessional team in the same way they did.

7.1.2 Belonging to the team

Belonging is a fundamental component of the Heideggerian phenomenological concept of Dasein (Leonard 1994), where Dasein refers to the person who is exploring their Being (Wisnewski 2012). Heidegger explained,

> "*Dasein itself -- and this means also its Being-in-the-world --gets its ontological understanding of itself in the first instance from those entities which it itself is not but which it encounters 'within' its world, and from the Being which they possess*" (Heidegger 1962, p. 245).

In this way, the concept of Dasein helps us understand that belonging comes from others; belonging is not something that we bestow on ourselves (Crowell 2007). Therefore, practitioners in this study were identifying the behaviour of other practitioners as outsiders to the core team in a manner that could be ascribed to be Dasein. Therefore, these others were peripheral in the team. In other words, practitioners on the periphery were the ones who had a defined set of criteria regarding how they were working within the team. Similarly, core team members

had a constructed label because they were differentiated from those who chose to be on the periphery. However, some core team members appeared to judge those who remained on the periphery as *'lacking maturity'* and not making the program *'a priority'* in their schedule, which suggests that they felt more strongly that the behaviours of the peripheral team members were not just different but were barriers to the interprofessional practice approach.

A widespread assumption in healthcare is that shared commitments characterise interprofessional teamwork and team identities (Aase I, Hansen and Aase K 2014; Lyubovnikova et al. 2015; Reeves et al. 2011). This assumption is underpinned by a view of teamwork where all team members are immersed in the vision, their individual interests are overridden, and instead, their interests are aligned to those of the team (Findlay et al. 2000; Slater et al. 2015). However, unlike teams where everyone has a single role and responsibility only to the team, practitioners in primary health care need to work across different care settings, within the same organisation, or between multiple organisations.

The practitioners in this study suggested multiple reasons why some may have been more peripheral to others on the team. For example, one practitioner suggested a contributing factor for team members' demarcation into core and peripheral groups was likely to be the part-time nature of their roles. In this study, all practitioners were employed part-time and allocated to the interprofessional team as a subset of their overall role. As this applied to all team members, this was not the defining factor in determining whether practitioners were central or peripheral within the team.

Another factor suggested by practitioners to contribute to the differentiation of practitioners to core or peripheral team members was the client's need for some services relative to others. For example, a remedial massage therapist was brought into the team to meet the client's needs for this service. The remedial massage therapist may have been considered peripheral due to her different role (i.e. not being part of joint therapeutic sessions); however, she did attend interprofessional team meetings. Chan et al.'s (2010) study also found that some roles were not considered equal to others in the interprofessional team. These were designated as '*shadow*' roles, that were newly created to meet the needs of the interprofessional program. For example, team members who were reception and nursing staff in usual care settings played new roles in the interprofessional team including triage, support, advocacy, and listening to the client's needs (Chan et al. 2010). However, these shadow roles often went unacknowledged by other team members or were considered as support roles in the interprofessional team, as these team members were also considered to have support roles in their usual care setting. However, unlike the shadow roles in the Chan et al. (2010) study, some practitioners in this current study who were differentiated as being on the periphery were counsellors who were part of the initial joint therapeutic sessions for the clients and, therefore central to their care.

Another consideration for why some team members were differentiated as peripheral was the suggestion from these team members that they did not have time to participate in the interprofessional activities due to heavy caseloads in their usual care settings. In a review of studies of conflict on interprofessional primary health care teams, Brown et al. (2011) reported managing workloads and a lack of time management as barriers to teamwork resulting in practitioners not

participating in interprofessional activities. Other studies, such as those of Morey et al. (2002), and Wilkes and Kennedy (2017), also reported a lack of time to allocate to interprofessional activities as a barrier to this approach. However, in this current study, peripheral team members displayed a distinction in allocating time to frontstage interprofessional activities while avoiding backstage activities rather than not participating in the overall interprofessional approach.

The behaviour of preferencing frontstage compared to backstage activities of the team members considered to be peripheral in this study raises questions of whether some practitioners found it more difficult than others to let go of traditional patterns of interaction to allow more collaborative patterns to take their place. This behaviour aligns with reports by other researchers who suggest some practitioners are more capable than others of working interprofessionally (Hammick et al. 2009; Hudson 2002; Thistlethwaite 2012). This difference in capability may indicate that the burden of accommodating to new patterns of interacting and relating may be different for individual practitioners, across professions, and in different care settings (Thistlethwaite 2012). Confounding this behaviour pattern, the benefits of participating in interprofessional activities were perhaps not as apparent to these peripheral members. Instead, these practitioners decided to continue with their usual working approach, demonstrating impermeable professional boundaries to the interprofessional approach's backstage activities.

7.1.3 Enacting professional boundaries

Professional boundaries, first introduced alongside *'Boundary Theory'* by Edgar Schein (1971), can be understood as,

"*Interfaces, clear dividing lines between areas of different ownership or shared areas of contact and can be seen in different contexts (e.g. professional, territorial, cultural)*" (Jones 2007, p. 355).

Permeability in role boundaries relates to the degree to which a role allows one to be physically located in the role's domain but psychologically or behaviourally involved in another role (Ashforth et al. 2000; Pleck 1977). In the current study, the practitioners' critical areas of conflict were issues around time constraints for new activities, such as team meetings and training, and prioritising their client contact time, to ensure they were not at risk of increasing their already heavy workloads. Practitioners attending the interprofessional backstage activities voiced frustration with others who were not taking the time to attend and felt they were missing out on these valuable interprofessional program activities. The cost for these practitioners of protecting boundaries from change was to remain on the interprofessional team's periphery in the eyes of other team members.

MacNaughton, Chreim and Bourgeault (2013) stated that the inflexibility of professional boundaries could hinder client care and professional relationships on the team, as they are often created as a reaction to practitioners feeling that they have new and unjustified additional responsibilities added to their professional role. The underlying fears that can lead to resistance around role changes are not well addressed in healthcare and may be exacerbated on interprofessional teams due to the complexity of factors in delivering care in collaboration with other professions (Hornby and Atkins 2008). MacNaughton et al. (2013) reported several factors that influence the reliance on professional boundaries in interprofessional teams, including structural elements such as workload and physical space; interpersonal elements such as leadership and education; and

individual attributes such as attitudes and values. In this current study, the overall workload was perceived to increase for many practitioners in the interprofessional team, despite careful consideration of this factor in the program's planning. That is, staff who participated could put an agreed number of hours aside each week or month to allow for the interprofessional activities that were acknowledged to be part of the program. The practitioners' avoidance of backstage activities, particularly team meetings, may be understood through the lens of boundary theory, as the practitioners were in control of their time allocations, and subsequently, their workload. The practitioner's fear of a perceived increase in workload may have led to an impermeable boundary behaviour isolating them from other team members.

Other researchers have also reported impermeable boundaries as a barrier when implementing an interprofessional practice approach. For example, practitioners have been found to use excessive workload and lack of time as reasons to avoid participating in interprofessional activities (Brown et al. 2011; Seneviratne, Mather and Then 2009; Wilkes and Kennedy 2017). Körner et al. (2015) also found that team meetings and other team processes requiring practitioners to be away from their direct clinical practice were barriers to participating in interprofessional activities. Examining why practitioners use impermeable boundaries in interprofessional teams, Fournier (2000) reported that professions maintain their identity in team structures through the process of isolating themselves from others who are not part of their own profession, through boundary construction. Therefore, it may be that the boundaries constructed by practitioners in this study were used to maintain the practitioner's professional identity and to signal that they were unwilling to fully embrace an interprofessional approach.

Brown et al. (2011) examined ways that team members could work through conflicts caused by impermeable boundaries by using open and direct communication strategies, having a willingness to find solutions, and being actively engaged in the development of conflict management protocols. Wilkes and Kennedy (2017) reported that understanding the rationale for team meetings as a critical process could enhance relationships and improve collaboration which in turn eased conflict. These researchers also found that time constraints could be used to compel practitioners to find novel ways of providing care. In the current study, practitioners discussed the program's process issues (e.g., lack of time for team meetings) with others on the team. However, no whole-team resolutions or innovations were put into practice. This lack of accommodation to address barriers to participation in backstage interprofessional activities idenitifed by team members suggests a lack of understanding of what changes needed to be made and how. It also suggests that the peripheral team members did not feel the backstage processes were critical to client care so could be missed without being detrimental to the frontstage activities.

Professional boundaries as barriers to knowledge sharing may also pose a challenge to sharing the discrete knowledge held by different professional roles (Fournier 2000). Currie and Suhomlinova (2006) reported that professionals sometimes act to guard their knowledge base using impermeable boundaries to protect their position concerning other groups. These researchers reported on the barriers to knowledge sharing introduced by policies derived from the National Health Service (NHS), which resulted in medical researchers and medical practitioners constructing impermeable barriers to effective knowledge exchange to protect their individual positions in potential grant applications. The outcome of

these constructed impermeable boundaries diminished the collective learning capacity across these two groups.

In this current study, practitioners were frustrated with those who did not attend team meetings, where professional knowledge was openly shared. Boundary theory may help us to understand that the frustration demonstrated by these practitioners towards their team members was not a lack of understanding the time constraints of their fellow team members. Instead, the frustration may have been caused by an understanding that the practitioners attending the team meetings lacked valuable professional knowledge input from those not attending. Practitioners' frustration with others lack of participation in backstage interprofessional activities is a critical finding in this study. This finding demonstrated that while team members engaged with the values of the interprofessional approach with clients (e.g. participation in joint therapeutic sessions), some did not demonstrate the same values for collaboration with their peers. This divided experience of the team members raises the issue about leadership within an interprofessional practice team.

7.1.4 The importance of leadership

In this study, the team members did not directly reflect on leadership within this new way of working despite questions within the interview guide in regards to roles and responsibilities between practitioners and within the team (see Appendix F). This lack of discussion regarding leadership within the team was surprising, given their acknowledgement that the interprofessional approach differed from their usual work processes. However, leadership, particularly within an interprofessional team, cannot be defined by a particular role or single set of responsibilities (Folkman, Tveit and Sverdrup 2019). Unlike a military-like

leadership structure of hierarchy (Soeters 2018), leadership within an interprofessional team has a greater horizontal relationship between roles (Ong, Koh and Lim 2020). Therefore, the role of interprofessional leadership may not have been recognised as absent within the team.

Three distinct leadership roles can be considered concerning specific responsibilities within an interprofessional team. The first leadership role is change management governance, ensuring processes from the previous approach (including roles and responsibilities) are guided successfully to the new approach (Antwi and Kale 2014). This leadership role was performed by the initiating practitioners of the study and the community health centre's management, providing the governance required for program oversight. A second leadership role within the team context is the clinical situational leadership, dependent on the client's clinical needs and the professional competencies to meet those needs (Anonson et al. 2009). For example, in a clinical emergency for a client, the practitioners within the team who have specific expert knowledge in the areas needed to meet this emergency would step up to the leadership role. The third role of leadership is the day-to-day guidance of the interprofessional approach within the new ways of working. Sims, Hewitt and Harris (2015) defined this role as,

> "*Teams have a clearly identified leader who sets the tone or culture of the team ... The leader provides a safe climate for constructive disagreement and ensures conflicts are resolved. They provide feedback on team performance and encourage reflection, openness and a learning culture*" (p. 212).

This third role will be considered as *'interprofessional leadership'* for the purpose of this study and remains the focus for the remainder of this discussion.

In this study, practitioners expressed an expectation of shared interprofessional leadership across the team (all team members would have equal responsibility for ensuring the interprofessional processes were maintained). Nevertheless, no transparent interprofessional leadership process was evident. Harris et al. (2016) reported that interprofessional leadership at the practice level is essential for collaborative decision-making to enable team members' new roles to be facilitated rather than being expected to emerge. In addition, having clear interprofessional leadership has been demonstrated to be essential for having a shared purpose, critical reflection, and innovation (Kirchner et al. 2004; McCallin and Bamford 2007; Xyrichis and Lowton 2008). Reeves, MacMillan and Van Soeren (2010) reported that interprofessional leadership is complex and needs to occur within a challenging landscape where professions have been founded on protecting their domains. However, in this current study, the issue was less about the complexity of leadership and more about the practitioners being focused on traditional care patterns without recognition of the critical role of leadership for change to occur effectively. Their lack of focus on the need for leadership therefore resulted in a lack of establishment of leadership responsibilities to drive the ongoing collaboration and interprofessional values within the team approach. This lack of leadership in interprofessional processes may have contributed to the demonstrated loss of team cohesiveness.

7.2 Consolidation of understanding

Through the interprofessional practice activities, the practitioners learned many things from each other. The consolidation of this understanding is discussed in terms of how the practitioners learned from each other, when and why role blurring might have been appropriate, what interprofessional skills training may have been required and how the practitioners utilised new knowledge.

7.2.1 Learning between professions

Within the safety of interprofessional backstage activities, such as team meetings, learning was encouraged between the practitioners. The practitioners were proactive in exploring areas of practice that made them feel uncomfortable regarding their experience and knowledge. Learning from others helped them consolidate their understanding of clinical issues and how to address the client's holistic needs. Some practitioners felt they gained confidence in their own abilities by sharing their knowledge with others. This sharing helped them appreciate how much they already knew from their own professional perspective.

Ongoing learning through interaction with multiple professions is one of the crucial mechanisms of being interprofessional. Harris et al. (2013) demonstrated that individual learning allowed practitioners to understand each other and understand client care, which led to improving the efficiency of the care they provided. As outlined in Chapter Two, general teamwork mechanisms (Salas et al. 2005) differ from interprofessional teamwork (Harris et al. 2013) with the mechanism of individual learning being a key mechanism within interprofessional practice but not within general teamwork. MacDonald et al. (2010) also reported that efficient

interprofessional practice depends on each practitioner developing knowledge of others' professional role. Similarly, Schot, Tummers and Noordegraff (2020) found that, alongside reported benefits to clients, interprofessional practice provided opportunities for practitioners to bridge gaps in professional, social, communicational and task divisions, negotiate overlaps in roles and tasks, and create spaces to allow the collaboration of each profession to be enhanced.

Within the team meetings and other interprofessional activities of this study, the practitioners recognised that team members were observing, listening, and sharing their past knowledge and exploring new areas relating to the needs of the clients. These learning mechanisms align with Gadamer's (1989) philosophical concept of the fusion of horizons. Gadamer explained the horizon to be the moment in time that holds everything that is already part of, and everything that can be seen, from where one stands (Gadamer 1989). Our horizon is continuously evolving through a process of fusion with other horizons. Horizons are time-related, constantly changing from one moment to the next, and therefore so are learning and teaching. In realising a fusion of horizons, the effect of historical knowledge cannot be ignored (Gadamer 1989). Chen and Jiang (2020) elaborated on Gadamer's fusion of horizons to align this concept with unity learning theory. This theory includes three main elements: watching, listening, and speaking, which are interrelated and thus cannot be separated (Chen and Jiang 2020). Hermeneutics, one of the pillars of IPA used in the analysis of this research study, also defines three perspectives, as defined by Smythe et al. (2007),

> "*The process of doing hermeneutic phenomenology is represented as a journey of 'thinking' in which researchers are caught up in a cycle of reading-writing-dialogue- which spirals onwards*" (p. 1389).

Combining these concepts of horizons and unity, Chen and Jiang (2020) stated,

> "*When the effective integration of different time horizons is realised, the learning process forms the unity of finite and infinite*" (p. 75).

This notion of combining past and present knowledge while looking to future knowledge aligns with the interprofessional concepts of learning '*from*' and '*about*' (both being in the past or present) and '*with*' others (looking to the future). In this study, practitioners demonstrated active involvement in learning from each other by sharing their vulnerability and seeking an understanding of other professions' perspectives. In doing so, other members of the team also benefitted from watching and listening to these interactions. They learned more than just the information being shared; practitioners gained confidence in the team's shared roles and developed mutual trust and respect through these learning spaces.

Through learning '*from'* each other and being able to see the client from another profession's perspective, practitioners in this study reported *'seeing more than they could see before*' about the complex nature of pain. This process is often referred to as *'walking in someone else's shoes'* (Haigh and Hardy 2011) or *'entering the phenomenological world of the other'* (Finlay 2013). Other studies have reported a new perspective can lead to more holistic solutions to complex problems by revealing details in a new way, prompting a different avenue of investigation (Green and Johnson 2015; Oandasan and Reeves 2005; Xyrichis and Lowton 2008). These views correspond with the studies of Bell et al. (2019)

and Nierenberg et al. (2018) who reported that practitioners had enhanced respect for each other's roles following their interprofessional practice experience, helping them understand and accept others' expertise. These studies align with the reports from practitioners in this study, which Adamson et al. (2018) term as *'interprofessional empathy'*.

7.2.2 When to consider role blurring

Interprofessional empathy can also be the first step in role blurring between practitioners on interprofessional teams. Sims, Hewitt and Harris (2015) defined interprofessional role blurring in this way,

> "*While professional roles are clearly defined, a shared body of knowledge and skill between team members means some elements of other professionals' roles can be taken on by others if needed*" (p. 23).

Some researchers have reported a critical factor in determining if role blurring would occur in interprofessional teams was the presence of role clarity, the distinct understanding of roles and responsibilities to share some of those responsibilities with others (Nancarrow 2004; Willard and Luker 2007). Role blurring (taking active responsibility for tasks within another professions scope of practice) was not described by participants within this study, suggesting that role clarity within the interprofessional team may have been lacking. However, other studies have reported that many practitioners prefer to have a clear division of mental and physical expertise in interprofessional teams due to a lack of confidence to engage in the other area of work (Foa et al. 2010; Knowles et al. 2013). Nancarrow (2004) also cautioned that boundaries must exist for role blurring to occur (i.e. an understanding of which responsibilities would be shared and remain

distinct to specific roles); without these boundaries, colleagues could be professionally threatened (professional image may be challenged).

The successful blurring of roles may depend on the clients' needs and the practitioners' experience in maintaining professional boundaries that align with their practice. For example, in a study by Foa et al. (2010), physical health practitioners felt they lacked the confidence to ask the client questions about their mental health, fearing opening a *'Pandora's box'*. The situation reported by Foa et al. (2010) represents a process of boundary delineation, rather than role blurring, which may place practitioners in a position of working outside their competence in subsequent client encounters. The balance of when role blurring is appropriate and when it may jeopardise client safety is not well understood (Schluter et al. 2011). However, researchers have reported that the mechanisms of interprofessional role clarity must be in place before sharing tasks across professions can be done safely (Nancarrow 2004; Willard and Luker 2007).

Clarity of interprofessional roles and interprofessional leadership to navigate these roles appeared to be deficient in the program that was explored in the current study. However, an example of contained role blurring was proposed by counsellors, who suggested the joint therapeutic sessions may provide an opportunity to teach physiotherapists basic counselling skills such as strategies that may help a client move forward when blocked in their therapeutic care. The counsellors envisaged these skills would be useful for physiotherapists to help manage clients whom they would otherwise refer to the mental health team for a consultation. Several studies have investigated the usefulness of psychosocial strategies within physiotherapy practice (Alexanders, Anderson and Henderson 2015; Driver, Oprescu and Lovell 2020; Suvinen et al. 2005), with respondents

reporting that knowing such strategies was important. However, they lacked tailored instruction on the use of such techniques at a level that was appropriate within their scope of practice (Driver, Lovell and Oprescu 2019).

7.2.3 Interprofessional skills training

Teaching skills across professions provides an opportunity for professional growth and starts to move towards a blurring of team roles on the interprofessional practice team. While the practitioners in this study hoped they could reduce the number of referrals to the mental health team in the future by having physical health practitioners skilled in basic mental health techniques, determining whether this extension of knowledge (and therefore their scope of practice) was beneficial to client care has not yet been explored (Driver, Oprescu and Lovell 2019). However, some studies have shown that many physiotherapists are aware of and use techniques such as motivational talk, cognitive behavioural therapy strategies, and social support to encourage clients to take an active role in their chronic pain management (Nielsen et al. 2014). While the practitioners in the study of Nielsen et al. (2014) felt that using such techniques was helpful in their practice, they acknowledged a lack of training for practitioners in complex client issues. Other barriers to incorporating these interventions in the practice of physiotherapists included time constraints within therapeutic sessions and role clarity (Arvinen-Barrow et al. 2010). Also relevant in this scenario was the teaching of appropriate skills in practical skills training instead of during client sessions, which was not discussed in this study (training provided to practitioners outside of the interprofessional training was not included in the study). It should also be noted that while practitioners discussed sharing knowledge across professions there was no evidence that controlled role blurring took place. There is also no evidence in

this study or others that the blurring of roles leads to more effective care (Sims et al. 2015).

While the physiotherapists in this study did not comment on any specific learning opportunities presented by the counsellors to enhance their psychosocial skill development, in general, the physiotherapists felt they had learned a considerable amount of new knowledge from practicing together with counsellors. In contrast, counsellors did not feel they had learnt as much from the physiotherapists regarding physical therapy. Both professions reflected on their increased understanding of the client's pain experience, but the source of this new knowledge was not equally apportioned to learning from the other profession. For example, the physiotherapists felt they had learned more about their profession by being exposed to the way counsellors work with clients. Specifically, one practitioner expressed an understanding that as a profession, physiotherapists always try to provide the client with something they can do to take away from a clinical session. This understanding became evident when she realised that counsellors do not always follow this same strategy. The counsellors did not report the opposite learning experience.

Other researchers have reported a similar disparity in how professions integrate knowledge from other professions through the experience of interprofessional practice in their approach to care, which may reflect a need for different approaches to learning between professions (D'amour and Oandasan 2005; Fox and Reeves 2015). The two professions in this study have highlighted vital issues when working in an interprofessional team: to what extent should practitioners take on the knowledge or roles of other professions, and if some blurring of roles is beneficial, can too much be detrimental to client care?

The findings in this study suggest that different approaches to learning between professions may be relevant for studies investigating the difference in knowledge between professions and what is required to bridge the gaps, or span the boundaries, of each profession's understanding of their scope of practice. Other studies have also suggested this need for varying approaches to training for professions. For example, Svensson (1996) reported the need to bridge gaps between professions' perspective on healthcare as a negotiation of hierarchies for each profession's responsibility rather than a means of enhancing collaboration. Correspondingly, Stenfors-Hayes and Kang (2014) reported knowledge gaps between professions were symptomatic of power struggles, relating to the negotiation of hierarchies Svensson (1996) found that where some professions use such knowledge to maintain or improve their position. In this current study, where practitioners collaborated in interprofessional activities, no such power struggles were evident to the participants. However, those who remained on the periphery did not share their knowledge within the interprofessional activities due to their absence from these activities, which may be demonstrating an act of power over others.

Schot, Tummers and Noordegraff (2020) highlighted that, for interprofessional collaboration to be successful, it must be continuously substantiated by the practitioners, rather than relying on management, educators, or policymakers. However, this view raises more questions than answers. For example, how do practitioners know when they have blended their knowledge enough to enhance the client experience, but not too much that they are putting the client's care in jeopardy? In terms of working in an interprofessional approach, how much relies on the negotiated support (role blurring) for each other's responsibilities to

enhance collaboration by reducing the burden of a bias in additional workload? An interprofessional approach assumes that individual learning will occur between practitioners but does not provide a process for utilising this knowledge. As an approach guided by defined values, interprofessional practice requires practitioners to draw on these values to navigate ongoing questions about client care within and outside of their collaborative practice. The values-driven approach requires an ongoing process of reflexive practice. Professions such as counselling and psychology have reflective practice through their foundation of regular supervision. In contrast, there were no formal structures to allow such reflexivity within the interprofessional practice in this current study.

7.2.4 Utilising new knowledge

In this study, practitioners reported utilising new knowledge gained from their interprofessional experience when in generalist practice. Counsellors reflected on the use of a broader knowledge of chronic pain gained from a deeper understanding of the biological processes of pain. At the same time, physiotherapists reflected on utilising their new perspective of chronic pain gained from their experience of watching and listening to the way counsellors' approach this issue with clients. In some instances, this new knowledge led to practitioners suggesting joint therapeutic sessions with clients who were not part of the current interprofessional practice team and came from different psychosocial backgrounds to the client cohort in the Branching Out program. These examples of new ways of working suggest that some practitioners had assimilated the knowledge gained through interprofessional empathy (Adamson et al. 2018) into their generalist practice (usual care). The assimilation of knowledge enabled them to understand when a joint therapeutic session with another profession would be helpful for a

new client. This use of knowledge in their usual care process (as a single practitioner) is different from the experience they gained from working within the interprofessional approach, which required the practitioner to accommodate their practice to adapt to working with others. Reports of practitioner experience utilising new perspectives of clinical issues gained from working in an interprofessional team are lacking. However, studies may have been reported on this topic using different terminology, making it difficult to compare with this current study. Expanding research of this nature, exploring how practitioners utilise the knowledge they have gained from their experience within an interprofessional team, may enhance our understanding of the sustainability of an interprofessional practice approach within a community health practice.

These first two themes*, 'My place within the team'* and *'Consolidating understanding'*, have explored how the practitioners felt they belonged to the interprofessional team and their experience of learning from each other. However, new healthcare approaches can create trepidation for those who design the new processes to ensure that they have considered the views of all those who will participate. The third theme to emerge from the practitioners' experience, *'Navigating the demands of an interprofessional approach'*, highlights areas from this study that needed to be strengthened for practitioners to practice effectively with an interprofessional approach.

7.3 Navigating the demands of an interprofessional approach

The interprofessional practice activities brought new challenges, requiring new skills and new ways of interacting with each other. This discussion explores the practitioner's feelings of anxiety and progression to confidence in practising in this

new way and how the practitioners supported each other in these new activities. Some practitioners were defensive in their approach to this new way of working, meaning others had to navigate around their professional defensiveness. While some other encounters exposed the practitioners to moral distress, which required additional new skills to navigate. For this study the term 'moral distress' used in accordance to the definition provided by Morley et al. (2019)

> "*a combination of (1) the experience of a moral event, (2) the experience of 'psychological distress' and (3) a direct causal relation between (1) and (2) together are necessary and sufficient conditions for moral distress*" (p. 646).

7.3.1 The need for experience

The nature of the practitioners' collaboration within the interprofessional approach ranged from anxiety during their early experience of joint therapeutic sessions to confidence and consolidation of knowledge over time. The exposure of their practice to others made the practitioners initially feel vulnerable to being judged by their peers. For example, one practitioner revealed her early anxiety of being embarrassed to practice together with another practitioner in the same session. She held fears of being revealed as someone with poor judgement or lacking professional knowledge. Some practitioners also highlighted a counter fear, not knowing what the other practitioner may ask of the client from a different professional viewpoint. This uncertainty left them vulnerable to exposure to areas of concern that a client would not usually reveal to them in a single profession session.

The fear of the unknown expressed by these practitioners aligns with the findings of others who have studied the experience of practitioners in unfamiliar care settings. For example, Snelgrove et al. (2015) revealed that newly arrived non-

locally trained specialists were largely left alone to acclimatise to meet service delivery needs in a London hospital. These researchers reported a bias towards a pedagogy of individual acquisition where more senior practitioners were required to learn on the job in this care setting. Thus, they experienced vulnerability to an uncertain expectation of their role, causing moral distress. Other studies have noted a similar experience with practitioners starting in their interprofessional practice roles (e.g. Garth et al. 2018; Lancaster et al. 2015; Seneviratne, Mather and Then 2009) with an increase in training and experience usually subsiding these fears of working with others. Being uncomfortable in these settings may be relieved with more intensive interprofessional training programs that were not available within this current study.

The practitioners in this current study were learning new skills and clinical knowledge through their collaborative process. For example, the use of a Socratic question technique (Paul and Elder 2006) was used by some practitioners in joint therapeutic sessions. Using this technique, practitioners' asked questions of other practitioners on topics relating to the clients' needs on behalf of the client. The Socratic question technique is regarded as a powerful tool for fostering critical thinking (Paul and Elder 2006) because of its emphasis on reflection and logic. A taxonomy of Socratic questioning contains six ways this technique may be used to explore and develop new insights: clarification, probe assumptions, probe reasons and evidence, elucidate viewpoints and perspectives, probe implications and consequences, and reflect on the nature of an issue at hand (Brown, Bannigan and Gill 2009). In this current study, the practitioners used this technique in many of the ways outlined by Brown et al. (2009). For example, the Socratic question technique helped the clients understand a topic in more detail (clarifications) and

helped the requesting practitioner (the practitioner asking the question) understand how another profession might communicate this information to the client (probe reasons and evidence). In addition, the practitioners felt the Socratic question technique helped them demystify issues they struggled with themselves (reflect on the nature of the issue at hand), allowing them to discuss the issue with more clarity in the future.

In this study, the Socratic technique was used spontaneously by practitioners as it was not part of the interprofessional training or their usual clinical skills training. The practitioners who reported using this technique were keen to explore clarifications and insights from other practitioners. The clients recognised this technique as a helpful way to draw out additional information on areas that were also of interest to them. This finding aligns with the study of O'Sullivan et al. (2018), who reported practitioners spontaneous use of a questioning technique with other practitioners during joint therapeutic sessions that helped elucidate information relevant to the client's holistic needs.

7.3.2 Relying on each other

Another reported benefit of practising with an interprofessional approach is the support practitioners can provide to each other when negotiating complex case treatment decisions (Anderson et al. 2017; Parker et al. 2013). In this study, practitioners highlighted the support they received from others in clinical decision-making during team meetings and on more informal occasions, such as when they met in corridors or reached out to each other for detailed advice. These new ways of interacting and learning were based on the practitioner's openness and receptivity to each other. Heidegger said, "*To think is before all else to listen, to let ourselves be told something*" (Heidegger 1971, p. 76). Aligning with this

philosophy from Heidegger, many of the practitioners in this study were open to the new experience. They worked together with practitioners from other professions to create a working environment that allowed learning moments to flourish. Thus, the support received from others added to the practitioner's knowledge, creating a fusion of horizons between past and present understandings of this client cohort's holistic needs (Gadamer (1989).

While each practitioner in this study was following their professional guidelines provided by the appropriate regulatory bodies for their profession, most were also open to the innovation of the program, finding new ways to work together. In this way, they were developing a new harmony and synergy within the team. These findings align with others such as Flood et al. (2019), who reported that practitioners benefit from openness to each other, the clinical setting's nuances, and the client's specific need to enable the working of a cohesive team. Baldwin (2016) also reflected on the practitioner's openness to each other in a program designed with an interprofessional practice approach. Within Baldwin's study, the practitioners described being receptive to others and their ideas, mainly through their body language and gestures, which aligns with the finding in this study of practitioners watching each other's body language in joint therapeutic sessions for cues to speak. Baldwin (2016) found that this openness led to an achievement of heightened awareness of opportunities and solutions that the practitioners would not otherwise have thought of themselves.

7.3.3 Reaching across professional divides

There is a paucity of literature on interprofessional joint therapeutic sessions. Those that have reported on the practitioner's feelings of participating in interprofessional activities of this type have provided mixed impressions from

practitioner feedback. Hubley et al. (2017) reported that working together with the client in interprofessional joint sessions enhances the practitioners' relationships. Kvarnström, Hedberg and Cedersund (2013) also reported that participation in interprofessional joint sessions provided the possibility of developing practitioner partnerships and co-producing services. These researchers' findings align with the feedback from practitioners in this study who felt the joint therapeutic sessions provided them with a space for deep collaboration and learning. However, Knowles et al. (2013) reported that pre-existing structures and norms that emphasise a division of labour between physical and mental healthcare were barriers to collaboration in joint sessions. A report of conflict in joint sessions was also reported by Shaw et al. (2008). In their study, these researchers concluded that systemic barriers for participation were discernible between practitioners and clients in joint sessions, posing challenges at organisational management levels of influence to address.

In this current study, the practitioner's practice was mostly siloed between physical and mental health practice for all of the community healthcare practitioners, except when participating in the activities of the study's interprofessional approach. As the organisational processes for practitioners and clients' participation were modified only for this study, the practitioners were required to move back and forth between their usual practice processes and the interprofessional practice approach. It is not surprising, then, that in this study some practitioners found it difficult to modify their practice behaviour in some clinical sessions and then return to more siloed behaviour for other clinical sessions. The discussion in an earlier theme (7.2 Consolidating Understanding) identified this discomfort and the need

for interprofessional socialisation training to enable the practitioners to develop dual identities to move confidently between the two care settings.

In addition to the interprofessional socialisation training needs, some practitioners in this study had insufficient training in an interprofessional approach to satisfy their practice expectations which left them vulnerable to moral discomfort. While most practitioners overcame these fears with experience, the early distress levels caused by this lack of training may have resulted in some other behaviours, such as professional defensiveness which resulted in avoidance of participation in team meetings. There is a paucity of studies that have investigated the training levels that may be required to prepare practitioners for interprofessional practice. Further, those studies that have included an investigation of training for practitioners (rather than prelicensure students) have primarily focused on the needs of nurses in practice (e.g. Murdoch, Epp and Vinek 2017). Comparisons between types of ongoing professional training to meet the needs of different professions are also deficient in the literature (Lawn, Zhi and Morello 2017). This study's findings indicate that when a structure of ongoing coaching in the values and vision of an interprofessional approach is not part of the team's normal process, it can lead to behaviours that create fragmentation. The lack of interprofessional leadership to drive the vision of the program in this study allowed some practitioners to comfortably reside behind professional defensiveness.

7.3.4 Navigating the barriers of others

Professional defensiveness is one of the signs of distress in a clinical setting and is used as a means for self-protection in different ways dependant on personality and context (Hewitt et al. 2003). In this study, some practitioners were protective of their time commitments for collaborative practice enacting impermeable

boundaries due to their perceived risk of work overload if they were part of interprofessional activities alongside their usual care commitments. These practitioners may have had the options to use time management techniques to block out time or schedule commitments appropriately to be authentically present at interprofessional activities they should have participated in as members of the interprofessional team. Instead, they used defensive statements (e.g. '*we can't do it all*') to avoid attending backstage activities such as team meetings which they perceived to be of lower priority than frontstage activities.

Some practitioners' defensiveness to participating in the backstage interprofessional activities observed in this study is typical of other studies that have reported a new interprofessional approach takes time for practitioners to adjust to (McCallin 2005). Indeed, this timeframe of adjustment has been reported to take up to several years,

> "*As newly formed teams of professionals come together to provide collaborative care for clients there will be evidence of former models of practice, until a group settles in and becomes familiar with their new working roles, responsibilities and relationships"* (McCallin 2005, p. 33).

Jackson and Bluteau (2007), in their study examining practice change to incorporate interprofessional learning opportunities in a clinical ward, found that the challenge was not in the change to the required clinical processes but in how to bring practitioners together to take ownership of the new way of working. Anderson and Thorpe (2010) provided similar messaging from their study, which examined practitioners adapting to the incorporation of interprofessional learning settings into their usual practice in primary care and on hospital wards. These

researchers noted that an organisational structure might impact heavily on even minor process changes that need to be negotiated carefully with the active participants. Other impacts to process changes noted by Anderson and Thorpe (2010) included the challenge of developing new activities where processes were already rapidly changing and barriers to introducing new learning activities which were not critical to a client's clinical needs.

McCallin (2005) warns that practitioners have been shown to fall back on usual patterns and networks rather than collaborate when faced with barriers to new processes. However, one of the facilitators to establishing these new process stems from the attendance of practitioners at activities such as interprofessional team meetings where dialogue is constructive and encourages colleagues to learn together (Kramer and Schmalenberg 2003). In this current study, the practitioners in team meetings were reported to show openness and actively question each other about concepts that concerned them. For example, one practitioner felt uncomfortable in a joint therapeutic session concerning information being provided by a colleague and so used the team meeting to ask this practitioner to explain her meaning. These team meetings became valuable learning encounters where the practitioners were also establishing stronger interprofessional relationships. Skjorshammer (2001) promoted that dialogue used in this way can help practitioners understand each other better and be an agent for developing creative thinking and promoting change. This value in team meetings in developing interprofessional relationships is likely to be another reason why the practitioners that did attend team meetings in this current study were frustrated with those who chose not to attend.

In this study, those practitioners who were noted to be on the periphery were frustrated with the new processes that seemed to require them to attend team meetings and potential training sessions, just as much as those who were part of the core team were frustrated with these peripheral members for the barriers they were demonstrating to active collaboration. Therefore, both core team members and those on the periphery showed signs of moral discomfort with the interprofessional practice approach. Moral discomfort and moral distress (a deeper form of discomfort) have been determined to have many causes, including emotional exhaustion, depersonalisation, and heavy workloads (Kinman and Teoh 2018). Identifying the reasons practitioners may choose to maintain boundaries to protect themselves from moral discomfort is essential to establishing processes that create sustainable work settings in interprofessional teams (Fumis et al. 2017) to ensure that the source of origin can be addressed.

In this study, there is a suggestion that practitioners from different professions may have acted differently in enacting impermeable boundaries, with the discussion of peripheral and core team members and that of resistance to taking part in the interprofessional activities only being part of the findings from counsellors and not from other professions. However, interprofessional activities with the client present were the source of the most prevalent occasions of practitioner discomfort reported in this study and several professions provided examples. An example of this type of distress was reported when practitioners felt overwhelmed by their values of social equity conflicting with those of the Australian government who were focused on border security. This conflict left the practitioners feeling that the government was causing additional harm to the clients that the practitioners needed to counteract in therapy.

7.3.5 Managing moral distress

Some areas of distress were created by the nature of having practitioners from different professions working together in the joint therapeutic sessions. For example, practitioners from physical therapy were confronted with clients' traumatic stories when they were not trained in coping with difficult discussions of this nature, leading to vicarious trauma. Other practitioners felt the joint therapeutic sessions took a long time and were an arduous process, making them difficult to justify if clients did not continue the interprofessional approach after completing this initial joint therapeutic session. Additionally, if the client then decided to only continue with one profession after these joint therapeutic sessions, some practitioners felt the discomfort of personal or professional rejection if they were not chosen to continue working clinically with the client.

Within this study, moral discomfort within the care environment was reported by a counsellor who reflected on a joint therapeutic session where he did not understand the clinical information provided to the client by a physiotherapist. In this situation, the counsellor remained quiet and did not verbalise their discomfort in front of the client. Instead, the counsellor brought the situation to the team's attention during a team meeting to better understand the physiotherapist's intent in the session and gain a more holistic understanding of the client's needs. In this way, the team benefitted from the practitioners' vulnerability in exposing the discomfort, which resulted in a learning situation. However, some familiarity with the overall client clinical need and how each profession approaches the client would help prepare practitioners from all professions on what to expect from clients and other practitioners in the interprofessional settings. Without training of this type, practitioners are subject to moral discomfort during their early stages of

working in an interprofessional team which could lead to distress and burnout if it is not addressed.

Although moral distress was initially conceptualised to address ethical issues in nursing (Corley 2002; Meltzer and Huckabay 2004; Rushton 2006), all healthcare professionals are at risk of moral distress and discomfort. The most likely causes are when practitioners are confronted with questions about the '*rightness*' or '*wrongness*' of decisions, treatments or procedures while feeling powerless to change situations they perceive as morally wrong (Fumis et al. 2017). In the example previously described where the practitioner felt fear in the room due to the physiotherapist providing information to the client that they were uncomfortable with, the discomfort for the practitioner occurred because they also held fears that the information being provided to the client by the physiotherapist was inconsistent with their own perception of appropriate advice. The counsellor felt constrained during the session, not wanting to change the course of the discussion. Vincent, Jones and Engebretson (2020) reported a similar episode to the one described in this current study, with a participant in their study of moral distress among interprofessional intensive care unit team members. In the Vincent et al. (2020) study, all 28 participants reported feelings of moral distress with anguish over client care decisions, working in an interprofessional team, and system-level factors. One participant in the Vincent et al. (2020) study noted that caring for vulnerable populations with significant language barriers complicated the situation and contributed to her moral distress. In the current study, it was impossible to determine if an interpreter was present during the joint therapeutic session with the counsellor and physiotherapist when the reported discomfort episode occurred (as the question was not asked at the time of the interview). However, all

sessions demanded that practitioners demonstrate cultural competency at all times, much like in the study of Vincent et al. (2020).

The example of a counsellor being unprepared for a complex discussion topic where there was a difference in professional perspective aligns with the earlier examples from this study where practitioners were not prepared for joint therapeutic sessions and feared practising with practitioners from professions different from their own. The training provided to these practitioners in preparation for the interprofessional approach did not include developing skills for coping with difficult discussions. This training deficiency raises questions on how much and what type of training needs to be provided to practitioners before embarking on a clinical setting using an interprofessional approach. The question of specific training on having difficult conversations is on the rise across all health professions and within interprofessional training (e.g. Brighton et al. 2018; Meyer et al. 2009).

7.4 Summary of backstage experience

This discussion of the practitioner's experience in the interprofessional approach during backstage interprofessional activities has followed three themes that emerged from the practitioner findings, '*My place within the team*', '*Consolidation of Understanding*' and '*Navigating the demands of an interprofessional approach*'. In relation to understanding where practitioners feel they fit within the team in this study, an insufficient drive of shared focus on the interprofessional vision may have contributed to some members acting in ways that led to them being considered peripheral by those who perceived themselves as core team members. Without interprofessional leadership that reinforced a shared vision and clear

purpose for the interprofessional approach, team members followed their usual care processes, prioritising their usual care clinical activities over interprofessional backstage activities in their busy schedules. Developing a deeper understanding of their professional role and that of others within the team was a new experience that the core members of the team valued highly. Therefore, this lack of shared time to establish interprofessional practices further isolated those on the periphery and created a division within the group regarding their sense of belonging to the team.

The second theme to emerge from the practitioner's experience illuminated the numerous ways the interprofessional activities promoted sharing of professional knowledge, which enhanced understanding. However, their learning levels and how they engaged in acquiring knowledge differed, even though the client cohort required both professions in their care. These findings provide a basis for questioning how the pre-understanding of the client's holistic needs may differ between the professions and, therefore, their requirement for different learning (training) levels to work together to meet the holistic needs of the clients may also be different. From this study, the suggestion of specific teaching from the counsellors to allow role blurring with the physiotherapists may also suggest new roles for these team members have started to develop. These new roles may resemble how the nurse practitioners' role developed from the blurring of roles between nurses and physicians (Gould, Johnston and Wasylkiw 2007; Harmer 2010; Kilpatrick et al. 2012).

The third theme to emerge from this study focused on the practitioner's ability to navigate the demands of an interprofessional approach in their day-to-day activities. The interprofessional approach provided support to the practitioners to

navigate complex treatment decisions, which were based on their ability to be open and receptive to each other. The joint therapeutic sessions were the interprofessional activity most differentiated from the practitioner's usual care and provided some anxiety for practitioners before they became more confident with experience. There is a paucity of literature exploring practitioner's feedback of an experience with joint therapeutic sessions. However, those who have reported on studies that included joint therapeutic sessions have found that they can be facilitators to interprofessional relationships (Hubley et al. 2017). Others have reported that they can become a barrier to practitioner working relationships if they expose a biased division of labour between mental health and physical health professions (Shaw 2008).

In this current study, the practitioners found it difficult to navigate between the demands of the interprofessional practice activities and their usual care. This finding aligns with others (Baker et al. 2011; Cameron 2011; Lloyd et al. 2011), who termed the division between interprofessional activities and usual care in-group and out-group behaviour requiring interprofessional socialisation training to enable practitioner's to develop a dual identity for transitions of this type on a day-to-day level.

Socratic questioning was beneficial for the practitioners in gaining information about a topic in greater depth, demystifying issues, and helping them understand different professional perspectives. However, many issues were raised concerning moral discomfort, which questioned the training level available to practitioners before commencing clinical encounters in an interprofessional approach. McCallin (2005) reported that it might take years for practitioners to adjust to the new interprofessional ways of working, while Kramer and

Schmalenberg (2003) encouraged practitioners to attend interprofessional activities such as team meetings where dialogue is constructive and encourages colleagues to learn together. Therefore, the findings of this study suggest that even though specific interprofessional training was not available for all practitioners, if the role of interprofessional leadership had been available and effective in the program, the practitioners may have been able to overcome some of the barriers to inclusive interprofessional activities, leading to more robust interprofessional team behaviour.

PART TWO: Frontstage – clients and practitioners at the interface

Within this discussion, a frontstage encounter is defined as when the practitioner directly interacts with a client in clinical treatment and care planning. Within an interprofessional care setting, the client may be with multiple practitioners, such as in the joint therapeutic sessions, or in a setting with one practitioner who then collaborates with the team in backstage interprofessional activities, as with the single sessions in this study.

In this section, the integration of findings derived from the analysis of the practitioner's interviews (Chapter Five) and the findings derived from the client interviews (Chapter Six) concerning their frontstage encounters are aligned and explored further with what is known in extant literature.

7.5 Finding the balance for the benefit of the client

While the interprofessional practice program was designed to meet the needs of the clients in this cohort, not all clients were ready to engage or trust in the

process from the start. The joint therapeutic sessions provided more time for the clients to share their holistic needs with the practitioners, and for many this was a time for the development of mutual trust to begin. However, some clients struggled to understand the benefit of the program, and two dissenting pathways emerged from the experience.

7.5.1 More time and more information to share

In all healthcare encounters, clients and practitioners harbour information, beliefs, and values, encompassing their knowledge and concerns, along with their preconceptions and life experiences (Tjørnhøj-Thomsen 2009). Nevertheless, they cannot always share these views due to time limitations in clinical sessions (Victorian Government Department of Health 2011). The initial joint therapeutic sessions in this study were designed to provide additional time than usual clinical sessions (90 minutes, compared to the usual 60-minute sessions). This additional time in sessions was intended to allow the clients to reveal details about their holistic needs and the practitioners to explain their views and provide information from the perspective of their different professions.

In chronic care settings, the client's ability to share information about their lifestyle and social circumstances is vital. The clients must carry out treatments in their own home or social space that corresponds with their lifestyle (Novak et al. 2013). Therefore, the practitioners need this information to understand what the client is up against when implementing a course of action to consider possible options appropriate for the client's specific preferences (Hunter and Segrott 2008).

In this study, the sharing of details of the client's personal and social context was essential, as the practitioners shared little background in common with their clients

in terms of their experience as refugee and asylum seekers. While the practitioners had received training in working with clients of this background, a comprehensive understanding of the client's needs could only be achieved by listening to their individual stories. For example, one practitioner noted a difference in stress levels observed with clients who were asylum seekers compared to those of refugee status, making it more difficult for them to attend sessions. This practitioner supported those clients who were asylum seekers a little more, providing them with options for attending, and showing her support for their efforts to attend when they could. Another practitioner felt that clients who were asylum seekers had an additional strain on them due to unjust actions of the Australian Government and media agencies. This practitioner expressed his feelings of an additional burden within his role to provide these clients with counselling support to help counteract these government and media activities.

While the embedded values of the interprofessional approach provided a solid framework for working with clients who hold different cultural beliefs, the practitioners aimed to implement these interprofessional values in all aspects of the program by demonstrating activities of cultural competence. For example, an essential aspect of the program was ensuring the clients could comprehend the confidentiality of the information they shared with the practitioners. The practitioners discussed how they tried to frame this information in different ways for the clients to ensure that it was meaningful for them.

One of the techniques used by the practitioners to demonstrate this sharing of information was in the short joint meetings in-between single sessions. In these sessions, the practitioners passed on the client's information gained in the first single session with the client to another practitioner with whom the client was

about to meet. The client was present for this sharing of information and appreciated that the practitioners were exchanging relevant information from one session to the next. In this way, the client understood that they would not need to repeat information, and details of the client's needs could be known to the next practitioner to further explore these details from their professional perspective. The efforts of the practitioners were appreciated by the clients, who commented on being thankful for the practitioners' safety messages at the beginning of each session (that all information would be maintained confidentially within the team, that they did not need to provide uncomfortable information, and they could stop the session at any time), and the visible sharing of information between single sessions. The confidentiality and visible sharing of information made the clients feel confident that they knew what was happening with the information they provided to the practitioners. They trusted how their information would be shared and used by other practitioners within the care team to enhance their care quality.

In the sharing of information, the practitioners' ability to demonstrate cultural competency rather than working with cultural sensitivity was critical to the effectiveness of the care setting for the clients in this study. Cultural sensitivity is the ability to be aware of cultural differences and similarities between people without assigning them a positive or negative value (Henderson et al. 2018). Cultural sensitivity is important because it promotes respect between cultures and can reduce cultural barriers between practitioners and clients (Danso 2018). In contrast, cultural competence in healthcare is the set of behaviours and attitudes that considers the clients' cultural background, beliefs, and values (Betancourt, Green and Carrillo 2002). Therefore, cultural competence is visible to the clients,

which helped the practitioners overcome the barriers they faced due to the communication difficulties between themselves and the clients in this study.

In all their encounters, the practitioners and clients faced barriers to communication. All clients had English as a second language in varying degrees of competency, and some clients were illiterate in their home language. Many clinical encounters required an interpreter so that the practitioners and clients could understand each other. The practitioners ensured that the clients could select the interpreters of their choice in these sessions by language, dialect, and gender. In this way, the practitioners were showing their sensitivity to the cultural language needs of the client.

However, understanding the program was made more difficult by the cultural differences in general linguistic competence, health literacy and expectations between the practitioners and the clients, leading some practitioners to doubt the program's clarity for client encounters that required interpreters for support. The practitioners tried to compensate for these intercultural communication difficulties by repeating information in multiple ways and then ensuring the clients acknowledged their understanding of the information before moving on to the next part of the session.

A specific area of need for many clients was the healing of their psychological pain that often accompanied the physical components of their chronic pain condition. For example, one client described how she recalled memories of past events with her practitioners in the initial joint therapeutic session arousing emotional pain. In this session, she was distraught but continued retelling her background life events as she found the talking process helped her. Being listened to and seen as a

person who overcomes challenges was the most important aspect for her. The practitioners knew that her psychological pain needed to be addressed to help her manage her physical pain (Turk and Okifuji 2002). While needs are specific to individual clients, the ability to listen and incorporate holistic needs into the client's treatment goals as part of shared decision-making has become a part of providing high-quality healthcare (e.g., Cott 2004; Tronto 2010; Woltmann and Whitley 2010).

Many researchers have stated that shared decision-making must be viewed as an ethical imperative, respecting the clients right to information and ensuring that their informed preferences are the basis for their individual care plan (Coulter and Collins 2011; Elwyn et al. 2013; Tilburt et al. 2014). Similarly, interprofessional practice is an ethical, values-based approach to healthcare that strives to deliver care concordant with client preferences (e.g., Giusti et al. 2020). Therefore, Forman, Jones and Thistlethwaite (2014) stated that shared decision-making must be a primary focus of interprofessional practice in chronic care settings. Congruent with other studies, the longer time provided in sessions, and open sharing of information within and between sessions in this study, demonstrated the practitioner's active support for information sharing as part of the process of shared decision-making.

Despite the social and language barriers reported between the clients and practitioners in the interprofessional teams, the practitioners provided many anecdotes of how they felt most clients were supported by the team approach. The practitioners felt these clients saw the team as *'wrapping around them'* and were happy with being treated as *'important enough'* for the team support. While many clients responded similarly, heralding support from the team approach,

some did not feel supported and expressed frustration with the program overall. The difference in the way some clients responded to the team approach than others may have been in the ability of the practitioners and clients to develop mutual trust with each other in the team setting.

Developing mutual trust between practitioners and clients is a critical factor for ensuring a positive therapeutic relationship and enabling everyone to work together to develop the best treatment options for the client (Price 2017). Thus, mutual trust is a critical determinant of effective interprofessional teamwork (Harris et al. 2013). However, there is a paucity of literature investigating the development of mutual trust within an interprofessional approach to care. Specifically, outside of this current study, research has yet to explore trust within the context of an interprofessional practice approach that includes joint therapeutic sessions where mutual trust is required between the client and the practitioners from different professions. In this study, building mutual trust was reflected in the experiences of the practitioners and the clients, with some strategies in these sessions seen as facilitators and others as barriers to developing mutual trust.

7.5.2 Developing mutual trust

There were several facilitators to mutual trust discussed by the practitioners and the clients in their interviews. For example, most clients showed vulnerability and openness during the initial joint therapeutic sessions in providing detailed stories of their life events. This level of trust aligns with that reported by Mayer, Davis, and Schoorman (1995), who defined trust as the willingness to be vulnerable to another individual, or group, where risk-taking behaviours within the relationship (e.g., sharing secrets, admitting failure, help-seeking) manifest that trust. Therefore, in this study, the sharing of information in a space where the clients

understood and were reminded of their rights to confidentiality and the ability to stop the session at any time supported the development of mutual trust. The clients were aware that the practitioners would be sharing their information within the team, and most of them felt comfortable, noting that they appreciated the messages of confidentiality. In this way, the clients trusted the practitioners' word to keep their secrets when revealing their holistic needs.

From the practitioners' perspective, mutual trust was evident in how the clients showed appreciation for the team's support. Many practitioners felt the interprofessional practice approach developed trust with clients by building a sense of dignity for how the clients were being listened to and respecting the information they were sharing. The initial joint therapeutic sessions were often emotionally charged, but both the clients and practitioners worked together to show patience and support in sharing this vital information. The visible team approach made the clients feel special and supported, which provided a deeper connection to the practitioners than they had felt in previous healthcare encounters.

Another strategy used by the practitioners to facilitate mutual trust was their advocacy with internal and external agencies on the client's behalf. For example, one practitioner reported advocating for clients with an external job network and external health services. Another practitioner reported team advocacy within the program that supported the client's communication of their care plan by ensuring the client was aware of missed appointments with another practitioner and was able to reschedule. The advocacy role of the practitioners aimed to provide the clients with some certainty that they could communicate with any of the

practitioners within the team and with other agencies to ensure their health and social needs were met.

Hardin (1993) reported that a person could decide to trust another person based on past experiences in similar situations, suggesting that the client's trust is based on their experience of advocacy, patience and support, from their experience of these traits in past healthcare encounters. However, many clients came to the program in this study with negative healthcare preconceptions from their home country and some with negative preconceptions of their previous healthcare interactions in Australia. Therefore, it would seem that the trust the clients have developed has come mainly from their interactions with practitioners within this interprofessional care setting.

Hardin (1993) explains this perspective of trust based on the client's experience to be at a day-to-day level that he describes as a street-level epistemology. Within this perspective, Gilson (2003) reported that trust can be measured by cooperative behaviours. In this current study, the finding that clients were regularly taking home exercises from their sessions and performing them in the manner prescribed by the practitioners may reflect this street-level of trust. Another example of street-level trust in this study may be reflected in the activity of practitioners and clients when meeting together in-between single clinical sessions to co-schedule their ongoing sessions together. In this example, the clients observed the team support from the practitioners in meeting with them face-to-face to schedule these sessions and accommodated the client's needs within the co-scheduling of appointments. These shared sessions between single session appointments became valuable to the clients and the practitioners. Time could be saved travelling for the clients, and one interpreter could be engaged as a single booking

easing the practitioners' workload. The clients then attending the scheduled appointments reflected a street-level of trust for the practitioners, demonstrating a two-way level of trust developing within the team.

7.5.3 Using questioning techniques

Another technique used by the practitioners in this study to facilitate mutual trust was Socratic questioning. In this technique, one practitioner asks another practitioner a direct question to help elucidate greater detail about a given topic of interest for the client (Brown, Bannigan and Gill 2009). Most of the clients noticed the practitioners' deliberate Socratic questioning activity during these sessions and commented on its usefulness. Some clients felt this questioning technique provided a role for the '*listening'* practitioner while the other practitioner exchanged clinical information. Providing a role for all practitioners in the team was reported as lacking in Burdick et al. (2017). These researchers reported that some clients felt interprofessional sessions with them (rounding at the bedside in chronic care within a hospital setting) were led by the physician in the team, while other team members failed to contribute. The clients in the study of Burdick et al. (2017) felt that these '*listening'* practitioners had something that they could have said but did not. Therefore, in this current study, the Socratic questioning technique may have been valuable in demonstrating to the clients that all practitioners were there to contribute.

The Socratic questioning technique was also seen as beneficial for clients in having practitioners ask each other questions that the clients would not have had the courage to ask themselves. Listening to the practitioners ask questions of each other also encouraged clients to become comfortable asking a practitioner questions to help elucidate information they needed that the other practitioners did

not provide. The teasing out of information through the Socratic questioning technique in this study aligns with O'Sullivan et al. (2018). These researchers found that clients appreciated practitioners asking questions of the appropriateness and acceptability of strategies proposed by other practitioners within joint therapeutic sessions. Clients in the O'Sullivan et al. (2018) study felt supported by this question and answer activity, reporting that it helped them to feel part of a '*team*' with the practitioners. Further, the clients in the O'Sullivan et al. (2018) study believed the Socratic question technique helped move the balance of power away from the practitioners and place the client in the centre of their care. Although the Socratic question technique has not been reported in other interprofessional practice studies outside of this current study and O'Sullivan et al. (2018), it has been demonstrated in this study as a valuable support technique that practitioners can utilise with clients in joint therapeutic sessions.

The Socratic question technique and street-level aspects of trust (discussion in section 7.5.2) were demonstrated as facilitators to mutual trust within this study. However, several barriers to developing mutual trust were also described as part of the practitioner and client experience of the interprofessional approach in this care setting. For example, not all clients were aware that they would be in a session with two practitioners in the initial joint therapeutic sessions. This misunderstanding of the care setting for these initial sessions was not anticipated by the practitioners who assumed the clients had been informed of the nature of these sessions during their intake interviews. However, some clients, for example, may not have understood the information provided in the intake interview or may have felt it not relevant to them.

7.5.4 Understanding why we are here

Another barrier the practitioners commented on was that some clients held a belief that they needed to attend the sessions based on another authority telling them to do so. For these clients, this authority was a referral to the program from their physician. This form of obedience to an authoritative figure is a barrier to building mutual trust with the client because the practitioners aim is to help the client become engaged with the program with an independent agency. Therefore, it may take much longer periods together to overcome the clients' obedience to the authoritative figure and learn to make their own decisions.

In general, in this study, the facilitators to mutual trust outweighed the barriers for most clients, and they were able to develop a positive therapeutic relationship with their interprofessional team. Through this relationship, most of the clients made breakthroughs in understanding their chronic care conditions, learning that the mental and physical components of their chronic pain were connected. For example, one client reported that she understood her emotional pain being relieved by doing exercise and being busy, which gave her the confidence to do things in other areas of her life. She was then able to talk about her chronic conditions with family without fear, providing necessary steps towards self-management of her condition.

Another client provided feedback concerning the interprofessional practice approach that the support of the different professions enabled her to gain confidence that she did not need to take medications any longer. The ability to self-manage her condition without medication was vital for this client to meet her responsibilities for her immediate family. Following this move towards positive self-management of her condition, this client attended an appointment with her

physician and demonstrated that she held a positive agency in her life decisions. Providing clients with the support to develop autonomy in this way was one of the interprofessional program's key goals.

The main positive comments towards the care setting reported by the clients in this study stemmed from their appreciation for the teamwork shown by the practitioners in their joint therapeutic sessions and the sessions held together in-between single practitioner sessions. Comparing these comments on client feedback to others in the literature was not straightforward as there is a paucity of studies with similar client cohorts or interprofessional care settings. Specifically, the direct reporting from clients on their involvement in care settings with two practitioners at the same time is scarce in the literature. However, some studies have provided small insights that align with this current study. For example, the study of Sitzia, Cotterell and Richardon (2006) provided client feedback on their views of interprofessional collaboration with clients in the development of services for chronic conditions. In the Sitzia et al. (2006) study, the clients deemed the most valuable support was provided by the interprofessional teams that were active and visible to the clients, as they were able to provide direct support for the client needs.

Kvarnström et al. (2012) also reported on client feedback following their experience of interprofessional practice approach where some of the clients participated in interprofessional team meetings. The clients in the Kvarnström et al. (2012) study reported positive feedback following their experience with the visible teamwork of the practitioners in the team meetings. This feedback related to the client's ability to become familiar with a greater number of professions offering services, equalising the professionals' expert role, and providing greater

support for the client's development. The study of O'Sullivan et al. (2018), previously mentioned in this discussion, also reported the client's appreciation for the visibility of the teamwork of the practitioners. In comparison, a study of interprofessional teams utilising an interprofessional pathway approach to care (where the client meets with one practitioner at a time who is relevant to their immediate needs, and the practitioners engage in interprofessional backstage activities) reported that clients did not find the teamwork of the interprofessional team important to them, as it was not visible in their day-to-day interactions with practitioners (Hewitt et al. 2015).

The common factor between these studies is the client's appreciation for the visibility of teamwork between themselves and the practitioners in frontstage activities when there are joint therapeutic sessions, in contrast to a care setting which only provides single practitioner sessions with the client frontstage, with interprofessional activities occurring in backstage interactions. In this current study, many clients who were actively engaged in visible team activities and developed mutual trust with their practitioners reported an increase in their ability to self-manage their chronic conditions. With alignment from the other studies that have reported on visible teamwork care settings with the client, this study's findings suggest that joint therapeutic sessions can provide enhanced support for clients through active involvement in visible teamwork.

7.5.5 Dissenting pathways

In this study, not all clients were able to move forward with self-management for their chronic conditions. The clients who did not move forward can be grouped into two dissenting pathways as they moved through the program. In the first dissenting pathway, the clients were able to accommodate the information

provided within the care setting but did not assimilate this information into their ongoing experience outside the program. In the second dissenting pathway, the clients felt the interprofessional program was not helpful to them and reported no change in their ongoing chronic conditions.

An example of concern regarding clients who appeared to be moving along the first dissenting pathway came from a practitioner who reported that some of the clients were not able to comprehend their right to choose within the program. This lack of agency left these clients unable to become actively engaged in developing a shared care plan. There were also examples in the client findings of those clients who seemed to be interacting in the program in this first dissenting pathway. For example, one client was able to describe the information they had heard during the program sessions but used the exact phrasing used by practitioners. The ability to retain this information is a first step towards assimilating it into her worldview but does not demonstrate that she was using the knowledge in her day-to-day life. Another client reported her dependency on the program, even after she had completed her program sessions. This client requested to be referred back to the program for additional support. At the same time, another client reported that as soon as she completed her sessions in the program, she stopped doing the exercises prescribed for her as part of her shared care plan. This client felt the exercises were too painful and not worthwhile, showing that she had not fully engaged in developing the care plan to a position where she felt empowered to continue self-management activities after the program completed. The clients who appeared to follow this first dissenting pathway during their time in the interprofessional program spoke favourably of the program but did not appear to have moved forward with their care.

In contrast, the clients who appeared to have followed the second dissenting pathway throughout their time in the interprofessional program did not speak positively of the program. Instead, these clients spoke of being frustrated and resentful of the information provided to them by the practitioners. The practitioners also spoke of these clients being frustrated with the program. The practitioners in this study felt trust between themselves and the clients was hindered if clients held a mismatch of expectation in what the program could offer. For example, one client reported a mismatch of his expectation and the program's clinical offering when he expected physical pain treatment in a physiotherapy session, which was not the service provided by the practitioners for the client's condition. This client's frustration stemmed from feeling that he had provided the physiotherapist in his care team with information about his needs but had not received anything of value in return. The practitioners felt this client could not engage with the interprofessional program due to not being able to let go of his healthcare beliefs. His expectations of what the program could offer and the prospects for him to be completely free of pain were not realistic.

Other researchers have reported similar findings where a mismatch in client and practitioner expectations were barriers to therapeutic care in an interprofessional approach. For example, Yelland (2011) reported that the communication provided to the client from the interprofessional team was not the only barrier to aligning expectations in their study. Sometimes, they found that there could be an apparent mismatch between what the client wants and what the healthcare service could provide. Seaton et al. (2020) also reported that managing client expectations and aligning advice between multiple practitioners is essential for therapeutic care. These reports of misalignment due to both internal and external

communications in this study and those of Yelland (2011) and Seaton et al. (2020) suggest a critical role for the alignment of the goals of an interprofessional program not only within the team but also within the organisation and the links the organisation has with external agencies.

The practitioners in this current study felt the amount of work this mismatch in expectation created for them in pre-intervention work was also frustrating. The practitioner's annoyance stemmed from their belief that the communication being provided to the clients before they attended the program was misleading and potentially resulted from another practitioner's way of passing the clients problem onto someone else. This mismatch in communication provided to the client from different sources demonstrated a lack of interprofessional communication between the referring practitioners and those within the interprofessional team. Foronda, MacWilliams and McArthur (2016) stated that interprofessional communication is not just about increasing or improving the amount of information shared within the team. It is also concerned with the way different professions and the client integrate the communication to enable effective collaboration. Therefore, to develop effective interprofessional communication, practitioners need to strengthen their collective, shared understanding of the client's needs and other practitioners' requirements so that communication is not misleading (Elwin et al. 2005; Schoeb et al. 2014).

Stewart (2018) reviewed the causes of a mismatch in practitioner and client expectations in interprofessional care settings in clinical studies. From the results of this review Stewart (2018) stated that clients often feel that they were *'stuck in the middle'* between opposing opinions concerning their care. Stewart (2018)

reported that clients are likely to become frustrated with the clinical service without a clear understanding of each other's roles and clinical expectations. They may become confused about whom to trust and which clinical advice they should implement. Examples of this mismatch in expectation were likely derived from pockets of professional protectionism (Wagner, Liston and Miller 2011), a lack of knowledge sharing between care providers (Foreman 2014) and contradictory mixed message miscommunications (de Vries-Erich et al. 2017). Within this current study, the practitioners worked together to counteract mixed messaging when they could. However, frustration with misinformation being provided outside of their control was particularly difficult to counteract, such as physicians' messaging when referring clients to the program. The example described earlier is typical of this scenario, where the client in this study drew an expectation from his referring physician that the interprofessional program would be able to relieve him of pain caused by his chronic condition.

In this study, one practitioner felt that the clients attending the interprofessional program saw it as a fresh start to their journey of relief for their chronic pain conditions. This practitioner felt, for example, that the messaging from the clients referring physician in the earlier example may provide additional pressure on the program's practitioners to find strategies to realign the client's expectations. The practitioner felt this additional burden on their practice within the interprofessional setting would be particularly difficult as the practitioners themselves were still learning the new concepts, values, and processes of this new care setting. The reflection of this practitioner on the multi-dimensional pressures of practising in an interprofessional care setting raises questions of how much training should be available for practitioners before they are actively involved in therapeutic care in

an interprofessional practice approach. Specific answers to the question of how much training should be provided are not available within this study or in the literature. However, there is a broad field of research investigating this issue, which includes interprofessional education at pre-licensure levels and ongoing professional development within clinical practice in primary care settings (e.g. Curran, Sargeant and Hollett 2007; Oandasan and Reeves 2005; Olson and Bialocerkowski 2014).

7.6 Summary of frontstage experience

The experience of frontstage interactions of practitioners and clients in this study align with others in the literature to suggest that an interprofessional practice approach may provide enhanced support for clients through active involvement in visible teamwork. In this study, the longer time provided in the joint therapeutic sessions allowed most clients to tell stories that incorporated their holistic needs, which became part of the client's treatment goals through a shared decision-making process. Despite the initial joint therapeutic sessions being the first-time clients experienced an interprofessional approach, many were able to show openness in sharing their in-depth holistic information. In doing so, these clients shared their goals and preferences and how their past experiences had affected how they were currently feeling regarding their chronic conditions with their practitioner team. The clients who shared their information felt comfortable doing so because they trusted the practitioners would maintain this information with confidentiality within the team.

The practitioner's displayed visible examples of cultural competency with the clients, which helped overcome barriers due to cultural differences between

themselves and the clients in this study. Some clients noted that the program had helped them develop the confidence to make decisions independently, with one client making it clear that this was the first time she had felt able to do so. All participants faced communication barriers due to the client's limited abilities with English as a second language, and most sessions required interpreters for communication support. The language barriers led some practitioners to doubt the program's clarity for client encounters that required interpreters. To counteract these concerns, the practitioners provided examples of ways they tried to compensate for these intercultural communication difficulties.

Both practitioners and clients provided examples of facilitators and barriers to developing mutual trust at a street level in interprofessional activities. The facilitators included the client's ability to be vulnerable in discussing their holistic needs with the practitioner team. Another facilitator was the practitioner's activity of asking each other's questions on the client's behalf. This technique helped the clients gain more specific information about their own needs and provided some clients with additional courage to ask questions of practitioners in later sessions. This activity led to a greater degree of certainty in the information being shared, which may lead to a greater degree of confidence for the clients in making decisions for themselves. Therefore, this technique helped support the journey for some clients in the program in developing autonomy, one of the interprofessional program's key goals.

However, not all clients reported a positive experience of being part of the interprofessional practice approach. Two dissenting pathways were reported. In the first dissenting pathway, some clients accommodated the information provided to them during the clinical sessions but did not go forward to incorporating this

information in their day-to-day lives. While in the second dissenting pathway, some clients felt frustrated with the interprofessional program caused by a misalignment of their expectations for relief of their chronic pain condition. The outcome of these two dissenting pathways was to put more demands on the practitioners to support clients who could not fully engage in clinical sessions. The needs of the clients in these two dissenting pathways suggest a more significant role for the practitioners in this study in developing engagement strategies. This question of the practitioners understanding the extent of their roles and responsibilities then also raises the question of how much training should be available for practitioners before they are actively involved in therapeutic care in an interprofessional practice approach.

Chapter Eight: Reflections

This chapter reflects on interprofessional practice as a phenomenon and whether the practitioners and clients of the Branching Out program experienced the phenomenon of being interprofessional. The strengths and limitations of the study are then discussed, along with the clinical and research implications and the researcher's reflexivity of the journey.

8.1 Is interprofessional practice a phenomenon?

A phenomenon, the *'thing appearing to view'*, is commonly defined as an observable fact or event (The Columbia Encyclopedia 2008). Immanuel Kant (1724-1804) introduced the concept of a phenomenon with its contemporary meaning when he theorised that a phenomenon was an incident or object that could be identified by humans through the use of their natural senses and was worthy of investigation. Therefore, phenomenon, are conceptualised to be the

things as they 'appear' to an observer, typically the person experiencing the phenomena. Phenomenon are not just those that are visually experienced, they may also be a mixture of sensory experiences, such as auditory and tactile experiences, emotional responses, memories, and prejudices, which expand on how the phenomena may appear to consciousness.

In contrast, Kant (1770/1949) theorised that all other things (the thing-in-itself), or things that can only be understood using reason or apprehended by the intellect, are noumena. For example, the experience of falling into a black hole is a noumenon. This experience can only be understood by reason as no human has ever experienced falling into a black hole – and lived to tell the tale.

The philosophy of phenomenology was conceptualised by Edmond Husserl (1859-1938) as an investigation of something experienced by the senses. He defined phenomenology as the '*science of the essence of consciousness*' (Smith 2006). While phenomenology is essentially focused on phenomenon, it is sometimes tuned to the things being experienced, and sometimes on the person experiencing the thing (Smith et al. 2009). Phenomenology attempts to explore how people make meaning of the phenomena they experience, for example, through their ability to describe the essence of the phenomena itself, as with a Husserlian approach to phenomenology, or sense-making of how the phenomena appears to them, as with an IPA approach to phenomenology (Smith et al. 2009). Therefore, in order to answer the question of whether an interprofessional practice approach is a phenomena, it needs to be established that it is something that can be experienced in consciousness '*in and of itself*', as the '*thing itself*', and does not only reside in terms of a theory or by reason alone.

When considering if interprofessional practice is a phenomenon, the observable experience of practitioners and clients working together in teams does not qualify interprofessional practice as being experienced in itself. Teamwork in healthcare has often been termed '*a complex phenomenon'* (e.g. Bell et al. 2018; Hirschfield et al. 2006, McDaniel and Salas 2018), but team members working together are not necessarily experiencing an interprofessional approach.

In Chapter Two the question '*what is an interprofessional practice approach*?' was explored and certain unique characteristics were determined to demarcate this approach in a healthcare setting from all other forms of team working. The distinguishing features of this approach were the interprofessional values-driven approach, team-based competencies, and the collaborative nature of the interaction between professions. That is, interprofessional practice has a structure, in its models and frameworks, it has values and processes, and it has an essence (spirit) which make it uniquely identifiable. Then, *'the thing'* is not just the moment of shared collaboration with other practitioners and the client, but also the state of mind, attitude, of becoming interprofessional, and expecting those same behaviours (driven by values) to be visible in others who are being interprofessional.

Using this definition of being interprofessional, in this research the practitioners and clients provided many examples of being part of an interprofessional practice approach that was identifiable from other forms of team working. For example, the practitioners were actively taking part in a values-driven approach in the care setting that complemented and added to their values of working in community health. They demonstrated a deep collaboration with each other in joint therapeutic sessions, taking cues from each other in verbal and non-verbal ways,

and complementing each other's practice with techniques such as Socratic questioning. One of the deepest forms of collaboration between the practitioners was recognised in the way they showed openness and vulnerability in team meetings. It was during these team sessions that the practitioners recognised their own learning from each other, and the learning of others from them. Within these sessions the practitioners acknowledged new perspectives from other professions and could put these into practice with clients within the program, and with new clients. In this way they were demonstrating an assimilation of this new knowledge into their ongoing practice. Some practitioners demonstrated an emotional response to the experience of interprofessional practice, being pleased to feel that they belonged to a team with the essence of being interprofessional, and also showing a frustration with those that did not become immersed in this way of working.

The clients also provided many moments of understanding they were part of an experience of interprofessional practice when the teamwork was visible to them, particularly within joint therapeutic sessions. The collaboration and values-driven approach of the practitioners was felt by the clients as they demonstrated active listening to the client's holistic needs. The teamwork competencies were also visible, particularly those of cultural competence.

Therefore, it can be determined that the practitioners and clients participating in the Branching Out program were indeed experiencing a phenomenon of being interprofessional. Not all embraced the phenomenon with the same openness, but all were part of this experience that made up the essence of an interprofessional approach in this healthcare setting.

8.2 Strengths of this research

The strengths of this study have been its ability to highlight the day-to-day experience of a team of practitioners and clients as they experienced working in a healthcare setting using an interprofessional practice approach for the first time. Because the experience was new to all participants, their awareness of the things that worked well and the parts of the process that were less smooth were top-of-mind. This immediacy of the events allowed the practitioners to recall specific experiences from their daily interactions. Similarly, the clients were also able to recall and discuss moments of the experience that were important to them.

All practitioners who participated in the Branching Out program agreed to participate in this research study, which also helped the study provide a complete and robust picture of different points of view of the experience. Those practitioners on the periphery of the interprofessional team might not have opted-in to the research study if others had decided not to participate. If only the practitioners who felt '*immersed*' in the program had participated in the research, it would have lost the ability to examine different perspectives of the interprofessional experience. The benefit of having the whole clinical team as part of the research study was to provide the scope for a robust discussion about the strengths and weaknesses of the interprofessional approach from different perspectives. For example, practitioners in the team had different experiences of the components of their day that needed to be adjusted alongside the new processes of working in the interprofessional team. Each of these differences was able to come to light through the IPA and be discussed within the context of theory and extant literature.

Similarly, the clients who participated in this study had a range of views of their experience of the program, which provided the opportunity to examine the views of clients who followed the two dissenting pathways, as well as the favourable pathway through the program. All of the clients who provided their time to be part of the research interviews were extremely generous in doing so. However, for the clients who did not feel that the clinical program helped them on their journey to managing their chronic pain, their perspective was crucial. It allowed the analysis to tease out these frustrations and align them with similar feelings from the practitioner's perspective. This triangulation of perspectives between the clients and the practitioners has opened up a rich understanding of how these dissenting pathways are experienced in this care setting. Information of this nature is just as important as the experience of clients who derived significant benefits from the program and felt they had made considerable breakthroughs in their ability to manage their clinical conditions.

Although the final analysis using IPA in this study was completed some time after the initial interviews, the time between was spent reflecting on this information from several different perspectives. During this time, the data was presented and discussed with researchers at local and international conferences, many of whom provided expert opinion and advice on the study direction. This ongoing exploration of the data also meant that the interviews were still active in mind when the analysis was undertaken with IPA. Also, at the time of analysis, a new immersion with the data was undertaken, listening to the recordings, reading journal notes, and reading the transcripts several times as the analysis proceeded. This immersion helped to bring the interviews back into a clear view and helped the analysis to proceed with as much information as possible available to hand.

Qualitative methodologies such as IPA are a recognised and trusted way of revealing the participant's day-to-day experience within study environments, such as this study if guided by recognised validation methods (Smith et al. 2009). The methods section outlined the process utilised in this study in detail, and examples of each stage of the analysis are included in the Appendices. In addition, the methods section provided a detailed account of the measures used in this study to ensure credibility, confirmability, dependability, and transferability of the findings as proposed by Guba and Lincoln (1981).

Smith et al. (2009) explained the explicit nature of IPA by stating,

> "*We ask questions about peoples understanding, experiences and sense-making activities, and we situate these questions within the specific contexts, rather than between them*" (p. 47).

In this way, Smith et al. (2009) highlight the power of IPA to elucidate an understanding of each individual's experience within a phenomenon and that one individual's experience is just as important as every other individual. Therefore, the utilisation of IPA allowed this study to appreciate each participant's experience as unique and bring these experiences together to provide a complete picture of the phenomenon of being part of this interprofessional care setting.

The value of qualitative research, such as this study, lies in its exploratory and explanatory power (Attride-Stirling 2001). This study has provided some clear indications of strategies that worked and those lacking in this specific care setting. The discussion section in this study has then allowed these strategies to be understood more deeply by aligning them with theory and extant literature. A deeper understanding of the parts of the phenomenon of interprofessional practice

within a specific study can help to influence policy and practice because it helps identify new strategies and their impact at the level of those that enact the processes that derive from those strategies.

The strategies developed within the Branching Out program and innovation of the development of the program itself were done to meet the needs of a specific client cohort, as identified by the practitioners who worked with these clients. Having a clearly defined clinical driver for this program is another strength of this study. The lessons learned through the experience of the participants have the opportunity to be immediately impactful in this clinical care setting.

Moreover, the interprofessional team included in this study reflected the general '*professional makeup'* of chronic pain management teams in community healthcare settings. It could, therefore, be argued that these findings are transferable to similar clinical contexts because they provide a rich and emic perspective of the team processes involved in delivering client-centered care using an interprofessional approach to clients with chronic pain.

8.3 Limitations of this research

Several limitations of this study drew from the convenience sampling of participants deriving from an active clinical program rather than a purposive group. The practitioners who participated in the program were already employed by the cohealth community health centre. Therefore, their experience, or not, of working with the particular client cohort or with an interprofessional approach was determined before the program started. The limitation that none of the practitioners had an experience of an interprofessional practice approach prior to

the program needed to be addressed within the program as it progressed. The recruitment of clients was also based on convenience sampling, which may have introduced bias as it relied on the invitation of practitioners.

Some limitations of the program impacted this research. For example, a time allocation limited the workshop training provided to the initial practitioners participating in the program and so could not cover all aspects of interprofessional education as would be covered at a prelicensure program within a university context. There was no opportunity to provide further training to those who joined the program after this workshop, so the practitioners who joined later were mentored by other practitioners already within the program. It is, therefore, not able to be determined how much information concerning an interprofessional practice approach was provided to new practitioners joining the program other than their clinical coaching in joint therapeutic sessions. Thus, this study could have been improved by interviewing the practitioners more often or over a more extended period to allow for a richer understanding of how the practitioners experienced the interprofessional approach as their exposure to the care setting increased.

As the Branching Out program was an active clinical program derived from meeting a specific client cohort's needs, this client cohort was the only one available to participate in this research study. The client cohort was from a vulnerable population which was detailed in the methods section. The vulnerability of this client group provided some challenges for the research study as they had limited communication (language barriers) and a limited understanding of the Australian healthcare system. These two factors combined to make it difficult for clients to convey rich information about their experience as

part of the interprofessional practice approach in their care setting. Another research study may address these limitations by repeating this study with a client group who can communicate their experiences and have had extensive experience in healthcare settings to compare their experience of an interprofessional approach with usual care settings.

It is unknown to what extent the clients interviewed in this study represented the overall demographics of clients in the program, as the details of clients who did not consent to be interviewed were not made available to the researcher. However, it is known that in some instance's clients from the same cultural heritage did not agree to be interviewed. It may be possible that different client feedback on the study's interprofessional activities would have been provided by the clients who did not consent to interview.

Clients were only interviewed at the end of their time in the program, so an improvement to this study may have been interviewing consenting clients as they started in the program or from the time of intake specifically to capture their feedback prior to the experience of interprofessional practice. In this way, changes may have been observed as they experienced being part of the interprofessional activities over time.

This study's original design utilised a case study methodology that guided the interview questions and interview approach for the practitioners and clients. The design of this study changed after most of the data had been collected. Some of the nuances of an interview designed for IPA may have been missed. For example, questions were prompted in ways that may have introduced bias when participants were slow or hesitant in responding, rather than allowing a full

exploration of the participant's experience. These potential biases were addressed with the methodology coach and highlighted in the text of this thesis, where they are relevant to methods and findings.

One of the factors of IPA that make it appealing to many researchers is that this method necessitates the active engagement of both the researcher and the participants within the interview process. However, the researcher has potential limitations that can introduce bias and personal opinions into the research (Linseth and Norberg 2004). Gilgun (2006) stated that researchers' personal and professional values and experiences are inherent in all research studies, making it challenging to set the preconceptions drawn from these prior experiences into the current study. I do not have a clinical practitioner background, which benefited this analysis, as it allowed me to view the professions equally without bias. However, I found that setting aside preconceptions of an interprofessional approach for this study's analysis was difficult. The setting aside and then bringing back any preconceptions was mastered with a methodology coach and supervisors who prompted me when these preconceptions started to appear in my work. In this way, the limitations of any preconceptions were set aside in this study to allow the process of reflexivity to strengthen the rigor of the findings.

8.4 Clinical implications

The experiences revealed by the practitioners in this study have several implications for others working in or intending to implement a program of care utilising an interprofessional practice approach. These implications are addressed as topics below.

Development of interprofessional processes

This study, along with others (Anderson and Thorpe 2010; Jackson and Bluteau 2007; McCallin 2005), have shown that the change in processes from usual care to an interprofessional practice approach can be an ongoing process over many months or years. Further, this process is not just about establishing new ways of working in an interprofessional approach but maintaining them.

In this study, the practitioners felt the interprofessional practice approach was aligned with the values of the community health centre they had already chosen to work within. This alignment of values provided a solid foundation for the new process, as did the principles driving the changes that stemmed from a recognised client need, which was then actioned by a group of practitioners who became part of the team's first members. This ground roots action for change for this client cohort fuelled the practitioners forward even when there was conflict within the team.

However, even with the tight cohesion of most practitioners within the team, there were barriers to all team members being fully engaged. One of the barriers for some practitioners was the perceived additional workload of the interprofessional approach, longer clinical sessions, greater need for discussions with other practitioners, and new activities - such as team meetings. These interprofessional activities need to be fully visible to any practitioners coming into the team and acknowledged for their benefits and the time allocations required.

The backstage activities were shown to be critical in this study as one of the non-negotiable aspects of an interprofessional approach and are just as important as face-to-face clinical contact. Therefore, backstage activities should be structured

as to when they are held and who attends, with processes to avoid any potential splitting of the team.

Practitioners in the interprofessional team

An interprofessional practice program is a constantly changing and innovating care setting. Those involved in selecting practitioners to work in this care setting should ensure that they have confidence, openness, and reflective practice. An interprofessional practice approach involving frontstage activities may include situations related to moral discomfort and professional boundaries. Therefore, the practitioners working in interprofessional teams need to be brave to take on new challenges, vulnerable to revealing parts of their own understanding that need strengthening and have an openness to the perspectives of other professions.

The selection process is vital and needs to focus on these critical areas of a professional approach to the care setting, alongside having a foundation of values-based practice. A structured process of onboarding is essential for practitioners coming into an interprofessional team, but this onboarding needs to be supported by other structures such as ongoing coaching and training.

Ongoing coaching and training

Some of the practitioners in this study found it difficult to juggle their workloads between their interprofessional practice activities and the needs of their usual care settings. Other studies have shown that practitioners need to develop dual identities to go back and forth between these two different ways of interacting with clients (Arndt et al. 2009; Baker et al. 2011; Cameron 2011).

The practitioners' experience in this study highlighted the valuable role of interprofessional training in preparing practitioners for their new roles within an

interprofessional team, aligning with other studies (e.g. Garth et al. 2018; Lancaster et al. 2015; Seneviratne, Mather and Then 2009). This training should encompass interprofessional values and processes, including interprofessional socialisation. Other areas for training should include an understanding of how other professions approach clients from their professional perspective.

Ongoing training as a team together serves multiple purposes, including increasing team cohesion and increasing learning, trust, and working within the process that arises from an interprofessional practice approach. The training topics should include specific processes that have arisen in this study, such as interprofessional leadership. The lack of specific interprofessional leadership in this study meant that the practitioners did not have a central point for guidance on conflict resolution for issues such as practitioners not attending team meetings or external organisations not being aligned with the purpose and role of the interprofessional program. When a team member suggested innovation, the lack of interprofessional leadership also meant that new processes were not trialled or implemented.

Reflexive supervision

The need for external leadership, reflexive team clinical supervision, and individual supervision were raised from this study to ensure the team dynamics are addressed and used to improve the team's cohesiveness. Reflexive supervision would allow complex issues, including professional defensiveness and issues related to vicarious trauma (depending on the client group) to be addressed. Some interprofessional approach processes were different from more familiar care settings for practitioners. The most prominent process that was different from usual care were the joint therapeutic sessions. In these joint therapeutic sessions,

practitioners were occasionally exposed to difficult conversations with clients outside their usual scope of practice. Some of these occasions caused the practitioners involved moral discomfort creating a question of the amount and type of support required for these practitioners to ensure they have psychological safety in the care setting. This finding suggests that psychological safety should be considered in all clinical practice areas that include joint therapeutic sessions or sessions that involve practitioners to be exposed to issues outside of their professional training.

Improving the client experience

The joint therapeutic sessions within this study provided valuable insight into the client's perception of being part of a team, as the practitioners' teamwork was visible to them within the sessions. The clients valued the safety messaging provided at the start of each session and the visible sharing of their information between practitioners in the joint therapeutic sessions and the joint sessions held between single sessions. Congruent with other studies, the longer time provided in the joint therapeutic sessions was seen as valuable for the clients (O'Sullivan et al. 2018), providing them with the time they needed to share personal stories and be listened to by a team of practitioners who made them feel special.

A barrier for client engagement was a mismatch in expectation between some clients referred to the program by their local physicians. This misalignment of expectation caused frustration for both the practitioners and the clients and brought attention to the need for the processes of the interprofessional program to be aligned not only within the organisation but also across any external organisations (Seaton et al. 2020; Yelland 2011)

8.5 Research recommendations

This study raised several new areas of investigation in the interprofessional field that warrant further research. The topics below explore these key areas.

Moral discomfort of practitioners utilising an interprofessional approach

The use of joint therapeutic sessions in an interprofessional practice care setting has not received much attention in terms of research focus. This study has highlighted several benefits of this approach for both practitioners and clients; however, it has also raised concerns that need to be investigated further. The practitioner's early exposure to joint therapeutic sessions raised anxiety related to peer judgement from other professions questioning the amount of training or support practitioners require to practice confidently in these sessions. The Socratic questioning technique utilised in the joint therapeutic sessions had several benefits of support for both the practitioners and clients but also raised questions of distrust for some clients due to a diminishing effect of the expert knowledge base of practitioners. The appropriate use of this technique warrants investigation to develop a protocol for use in future interprofessional care settings. The practice of some practitioners to *'drop in'* on other practitioners while in single sessions with clients (effectively creating a joint therapeutic session without warning to the client) was reported as beneficial for some clients in this study but raises ethical issues for wider use that require further investigation of this process.

In this current study, the practitioners had training in cultural awareness and trauma. However, these were not always sufficient to provide them with the preparation they needed for the difficult discussions presented within the joint therapeutic sessions due to the nature of discussion deriving from a professional

perspective that was different from their own. Additional research is warranted to investigate how to support practitioners with psychological safety to prepare them for practice in an interprofessional approach.

Another area of potential discomfort revealed in this study was the psychological safety of the clients in the clinical setting. The clients revealed that safety was vital for them to develop trust and share information in clinical sessions. The cultural competency actions of the practitioners helped to create that safety within the care setting. Early interprofessional practice frameworks did not make explicit the cultural competencies needed for this approach (Oelke, Thurston and Arthur 2013). While some countries are now including cultural competency training in their interprofessional approach, there is still debate on what focus this should have to be effective (Cahn 2020). Further, most interprofessional and cultural competency training programs are not integrated (Abu-Rish et al. 2012; Olson and Bialocerkowski 2014; Reeves et al. 2010), leaving a gap in preparing practitioners for culturally appropriate practice in a care setting that includes an interprofessional approach.

Another area of discomfort for practitioners in this study was that practitioners were not consistent in applying the interprofessional approach processes. Some showed resistance to taking part in backstage activities, while others suggested that they were not sure of how they could negotiate or innovate the interprofessional processes of the program framework. The findings of inconsistency in the interprofessional processes raised questions of adequate training, coaching and interprofessional leadership within the team in this study.

Interprofessional leadership, training, and coaching

The interprofessional training was provided in different ways for team members who joined early and joined later in the program. The early members were provided with hands-on workshop training from an experienced interprofessional practitioner. In contrast, those joining later were mentored by the team members who joined earlier and had some experience. Interprofessional coaching was not reported as an active process, and interprofessional leadership was not evident in this study setting. Further research investigating the provision of training, coaching and interprofessional leadership before embarking on programs that include an interprofessional practice approach is therefore warranted.

The lack of interprofessional leadership in this current study was linked to the fragmentation of the practitioners in the team and the degradation of the interprofessional processes over time. The field of research in interprofessional leadership has grown since the interprofessional program in this study was established. However, studies in specific areas of interprofessional leadership in the development and sustainability of interprofessional programs in chronic care settings are warranted. Similarly, studies in the use of training and ongoing coaching for practitioners in interprofessional care settings is warranted in terms of the requirements of specific training programs and the timing of training and provision in an ongoing delivery that aligns with the needs of practitioners in chronic care settings. An ongoing coaching role was suggested as potentially beneficial to support practitioners on a day-to-day basis in reflective practice, which also warrants further research.

The utilisation of holistic information in client-centered care

There is an old saying that goes along the lines of "*Why ask the question if you did not want to hear the answer*" (Hegarty 1968). In relation to this study, the question is slightly different and more in line with the ethical consideration - if you cannot act on the information, should you be asking the question? This study's findings revealed that the interprofessional practice approach supported the clients to reveal holistic information about their current and future needs in many areas of their life, not only related to their immediate healthcare needs. Creating a system capable of gathering such information in relation to clients suggests that we need to have systems capable of recording and addressing these needs.

It was outside the remit of this study to investigate how, or if, the practitioners could respond to all of the holistic needs presented to them by the clients. For example, some clients discussed their legal needs, while some revealed their housing or family issues which were not revealed within this study due to privacy concerns. Some studies have utilised an IPA approach to investigate the contribution to work in preventative health behaviours (e.g. Darker, Larkin and French 2007; Emiliussen, Andersen and Nielsen 2017; Flowers et al. 1998), which do include a more connected use of the client's biopsychosocial information in the care setting, but few changes have been made to help consolidate system changes in this direction. Further research is warranted, which helps to illuminate the type of system we need to create to enable the multiple needs of clients to be addressed.

8.6 Reflexivity

Reflexivity is concerned with how the researcher's beliefs and values affect the research study. Therefore, reflexivity is an essential component of the study's trustworthiness, as it allows the reader to have a deeper understanding of the context of the research from the researcher's perspective, allowing a judgment on how the researcher may have influenced the research. In a research study that incorporates an IPA framework, the use of a double-hermeneutic highlights the importance of reflexivity as the researcher's preconceptions are brought forward as part of the analysis (Shaw 2008). A list of preconceptions compared with findings is provided in Table 8.1 and further elaborated in the sections below.

Table 8.1 Preconceptions compared with findings

Reflexive condition	Example from this study
Pre-conceptions of expectations that were confirmed	Expectation that clients would increase their ability to self-manage their chronic conditions was confirmed for most clients
Expected findings that were not confirmed	Expectation that all team members would embrace the interprofessional practice approach in the same way, for example attending interprofessional activities, was not confirmed for all practitioners

Findings that were more prominent than expected	Findings that indicated the additional time required for practitioners to take part in the interprofessional activities both backstage and frontstage were reported by most practitioners more frequently than expected
Findings that were less prominent than expected	Findings that indicated differences in the client's abilities to cope with the interprofessional practice approach between those that held refugee status compared to those who had an uncertain visa status
Unexpected findings	The two dissenting pathways within the clients potential journey were unexpected outcomes
Reflexive condition	Example from this study
Pre-conceptions of expectations that were confirmed	
Expected findings that were not confirmed	
Findings that were more prominent than expected	
Findings that were less prominent than expected	
Unexpected findings	

Finding purpose and avoiding bias

The researcher's intent at the beginning of the study and the influences that shaped that study are an essential part of reflexivity. In the Prologue to Chapter One of this thesis, I reflected on why I undertook this research and how it will shape my ongoing work in leading teams and inspiring interprofessional collaboration. Whether my work continues in healthcare or technology innovation, or both, the essence of being interprofessional will be an important focus.

For the purpose of reflexivity, the role of the lead practitioner on this journey is significant as she was a part of this study from its inception in the clinical setting. We were both excited about the program and the opportunity to undertake this research alongside the program. The lead practitioner has been a key supporter and contact that enabled this study to progress over many years. In terms of the horizons we each brought to that first encounter and our ongoing understanding of each other, as Gadamer (1975) expressed as a fusion of horizons, the lead practitioner and I became well known to each other. I learnt a great deal from her about the clinical practice operations and some of the day-to-day decisions she made as a practitioner. I also learned how she and the other practitioners in the study spoke about their involvement and their language to explain this involvement.

An important part of my relationship with the lead practitioner was maintaining researcher neutrality despite the vital role she played in this clinical program. While we had several conversations regarding the research prior to the final analysis, my analysis of the practitioner and client interviews throughout the IPA

stages was done without input from the lead practitioner. Our earlier conversations and my own assumptions were put to one side to allow the IPA to unfold from the data itself. The lead practitioner was provided with a copy of the late-stage draft of the thesis for comment, but only after the analysis was complete. Any suggested comments made by the lead practitioner into the final thesis were made carefully after reflection to avoid bias of the findings or discussion.

A particular experience that resonated with me about the day-to-day interactions of the practitioners' work with the clients in the program occurred when I was given the directions to organise the interviews I would be undertaking with the clients. This experience gave me a firsthand understanding of what it was like to contact the clients using an interpreter phone service, setting up a suitable appointment time, and securing an appropriate interpreter for the interview. It was not a simple exercise as there were many steps in the process, and each one depended on the client, interpreter and myself to align and then turn up at the correct time and day. I sympathised with the practitioner's statements that these sessions took a lot more of their time. Understanding this fusion of horizons was important when I was interpreting the findings in the practitioner interviews. I consciously put my experience to one side with the initial analysis of the practitioner interviews and then reflected on my experience along with the transcripts in the second and third stages of the analysis.

The time spent reviewing this study with the lead practitioner is vital to the reflexivity of this research as my background is not in clinical practice. As discussed in the strengths and limitations of this study, my non-clinical background meant that I did not bring a bias to this study from the perspective of a specific

clinical profession. However, my lack of professional clinical experience was potentially a limitation. Therefore, my assumptions on clinical encounters were challenged and broadened by my conversations with my supervisors and methodology coach (who are all senior clinicians in their fields) along with the lead practitioner to help understand how practitioners and clients interact in clinical sessions. These conversations broadened my horizon on the training and preparation a practitioner brings to an encounter. This developing knowledge of clinical practice was forefront in my mind when analysing the practitioner findings. Another researcher, with clinical training, may have undertaken the analysis differently and indeed may have asked different questions in the interviews resulting in variations in the data collected. Furthermore, a clinically trained researcher may have brought a closer connection to the practitioners' clinical language and nuances from the start of the research process.

My reflections on undertaking the client interviews were provided at the start of the client findings. My background does not align very closely with the clients in this study, except in gender alignment with the women in the study (5/9) and their age (most were middle-aged). Some of the clients mentioned their children during the interviews, which brought a sense of familiarity to my mind as a parent. I tried not to bring preconceptions of life as a refugee and asylum seeker to my thoughts during the interviews or IPA of the transcripts, as I do not have a significant understanding of this field. My pre-understandings of this type of life were from brief encounters, the making of a short documentary film, and the Australian media. However, as this was a reasonably unfamiliar concept for me, it was difficult not to wonder how that experience must have influenced the client's

perception of the clinical setting and how I should accommodate these feelings during the analysis.

Undertaking IPA

Undertaking IPA was an unfamiliar process. As I started this process very late in the research, a methodology coach was considered a suitable way to ensure that the analysis followed the appropriate stages and approach. During our first round of practitioner analysis, the methodology coach and I examined a single practitioner interview and provided each other with our initial findings. In this first round of analysis, our interpretations were very different. Mine structured and categorised, hers insightful and meaningful. The aim was not for agreement but to find significant overlap. The search for overlap allowed the process of analysis to be discussed in depth. I went away and started again, this time with more understanding of how to find meaning in the practitioner's words. The process of working this way through the analysis of the first interview was repeated over and over. We repeated the cycle for each stage of this first interview until the final themes were identified and completed. I came to understand that IPA cannot be '*taught*' but has to be experienced to fully understand the key elements. So, this '*rigour check'* with a methodology coach allowed me to have confidence in my analysis. It addressed issues such as methodological rigour, reflexivity on assumptions, and managing the dual roles inherent within this research design. What was evident from this exercise was that the words of the interview do not speak for themselves. Another researcher may have brought different preconceptions and a different experience of the analysis process, allowing a different interpretation of the words to be illuminated.

The philosophical contribution of IPA to this study was also significant to how this study unfolded and the development of the findings. From the beginning of applying an IPA methodology to the practitioner and client interviews, I felt that the authenticity of the participant's actions was coming into the light. I struggled, as already mentioned, with the development of the IPA. However, with each stage, I became more satisfied that the IPA process could capture the participants' day-to-day experiences. The IPA methodology felt to me to have humility in its application, and so it allowed me to sit back and breathe without forcing the results to mind. My earlier frustrations with not demonstrating results from this participant group were put to one side, as I allowed the IPA process to reveal the findings, and I was excited to see where this analysis would lead. The process required not just bracketing of preconceptions – but letting go of old ways.

The research journey

The experience of this doctoral journey over the last seven years has been deeply interesting and meaningful. The journey itself has taken many twists and turns, but my interest in the meaning of teamwork and collaboration through an interprofessional approach to working together has not faltered throughout these years. While I started this journey looking for a way to answer a quantitative research question of the beneficial outcomes of interprofessional practice, my journey instead took me to a place where I learned to value individual participants' day-to-day experience. I was able to move away from assessing binary categories to thinking into looking at the whole experience from different perspectives. This new appreciation of lived experience as a way to give merit to the meaning of things people experience will stay with me in many future endeavours.

I consider my time in the early stages of designing this research study to be one of the most powerful moments in my career. I acknowledge and appreciate the support of my supervisors in providing me with the autonomy to follow the direction that had the most meaning for me. When the management at cohealth introduced me to the Branching Out program and the lead practitioner, I knew that I had found a worthy investment of research effort to help support and explore this clinical program. I spent many hours, days, months, and years reflecting on the work they were doing and how best to bring this program to light. Over many years and different international conferences, my supervisor from Curtin University became someone I admired in the field of interprofessional practice. I was fortunate that she agreed to become part of my supervisory team in 2019 to help steer this research in the right direction.

A serendipitous moment, less than a year ago, connected my research studies with the methodology of phenomenology and eventually to selecting IPA as the approach to reveal the deep insights I felt were hidden in the data I had collected. As someone who goes straight to the source to understand new things, I researched Professor Jonathan Smith, the founder of IPA, and his team at Birkbeck. I found their website which provided a list of methodology coaches in various countries who could help doctoral students navigate an IPA approach. From this list, it was my great fortune to be introduced to my methodology coach who has provided all the support I could imagine helping me understand how to apply IPA in its intended form to allow the findings in this thesis to emerge.

I have learned through this process that starting a doctoral journey with the right research question is only the first step in navigating to the end. Dutton (2003) suggested,

"*If you did not begin with research questions that tapped into your passion and abiding interest in a phenomenon, then it is likely you travelled away from your own centre of interest and curiosity*" (p. 6).

My interest and curiosity in interprofessional practice have only deepened through this experience. However, I have also learned that with the right team around you, the journey can go even further than expected. My research team have been my foundations of strength, providing critical feedback and pushing me to look harder and dig deeper at every twist and turn.

A rewarding outcome of reflecting on this IPA process was understanding the interconnectedness of the study setting and my own growth through writing this thesis. The IPA rounds of interpretation were reminiscent of my rounds of understanding of working in a clinical setting. These interactions were also reminiscent of my understanding of phenomenology and interprofessional practice. Through this research journey, I have a much clearer understanding of phenomenology and the process of interprofessional practice, both being an attitude or an understanding that is carried through deep experience. The findings and interpretations '*painted*' in this thesis are much deeper than I had envisioned when embarking on this journey – and I can now see more than I could see before.

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Appendices

Appendix A cohealth banner

Picture taken of the front entrance to the cohealth community health centre, November 2013 (Terri Dentry).

Appendix B Flyer provided to physicians for referral to Branching Out program

BRANCHING OUT: A holistic program to assist people of refugee and asylum seeker background to move beyond pain

The **'Branching Out'** team views pain as a complex human experience and works in a collaborative and client centred way to assist in their understanding of pain and pain management strategies. We support the client to look at new opportunities in life and build on their existing resources. We work in a culturally safe way and acknowledge the impact torture and trauma and settlement experiences may have on our client's health and wellbeing.

The WRHC 'Branching Out' Team:

- Counselling
- Physiotherapy
- Living Well (self-management support)
- Other services as identified by client needs

The client criteria:

- Refugee or asylum seeker background (issues linked to this experience in some way)
- Stable enough to work on the issue of pain management
- Able to attend regularly for appointments
- Interested in working with a team of staff around their needs

The Process: Please forward **referrals** to Melanie Block, WRHC 72-78 Paisley St, Footscray Vic 3011. Ph: 83984277 Fax: 96879330. Please include all relevant medical and social information on your referral and details of other care providers involved with your client.

The clients will be contacted for a thorough initial assessment of client needs with at least two members of the team. A plan will be developed with the client and their workers to support the client's goals. Client case conferences will be organised with the team and as a referrer you will be invited to participate. Clients will have access to individual therapy sessions and group pain education and physical activity sessions as needed.

Other information: 'Branching Out' is a trial program which has been initiated as the result of a WRHC internal grant. Clients who are referred to this program will be asked if they consent to be involved in the evaluation of the project which will include the collection of very simple outcome measures in a de-identified way and consent to be contacted for an interview about their experience with the project. Clients will be able to access the service even if they don't consent to be involved in the evaluation.

Appendix C Information provided to practitioners prior to consent to participant in the Branching Out research study

Page One of Two pages

VICTORIA UNIVERSITY
MELBOURNE AUSTRALIA

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH (clinicians)

You are invited to participate

You are invited to participate in a research project entitled **Branching Out: Assessment of IPP model of care in Pain Management with clients from Asylum Seeker and Refugee backgrounds**.

This project is being conducted by a student researcher Terri Dentry – College of Exercise & Sport Science as part of a PhD study at Victoria University under the supervision of Associate Professor Andrew Stewart from College of Sport & Exercise Science.

This project is also being conducted by the following staff from Victoria University and Co Health.

- Dr Lauren Banting – College of Sport and Exercise Science, Victoria University
- Dr Lyle Winton – Office of Research Services, Victoria University
- Melanie Block – Community Health/ Refugee Team Leader/ Physiotherapist - Co Health

Project explanation

You are invited to join a research project to assess a new approach to health practice at Co Health. This approach called interprofessional practice, utilises a group of health practitioners from up to three different professions to assist with client treatment. To evaluate this new approach the research team wish to collect some information. This will be in the form of a set of questionnaires and an interview which will be audio recorded. The interviewer would control the recording process, so that it can be stopped and started at any time and you can choose to withdraw your consent at any time without affecting your treatment.

The overall process will be familiar if you have been a clinician at the clinic before, as it follows the same pattern with some small modifications. At the time of client consultation practitioners from up to four health professions – Counselling, Physiotherapy, Living Well (Occupational Therapy) and Massage, will come together to listen to the client case presentation. The lead practitioner will be from the profession that the client may have booked into the clinic to see, or will be determined by the practitioner group. The practitioners will then present their findings together in a team meeting and discuss an approach to manage client care. The outcome will be discussed with the client and any suggestions about their treatment put forward for their consideration. Treatment will then be undertaken with client permission, as is the usual process and if the client feels that any additional treatments suggested will benefit them, then they will be free to follow these up.

What will I be asked to do?

In addition to reading this form you will be asked to complete a consent form indicating that you agree to participate in the research project. You may choose to take this form home and discuss it with a friend, family member or partner and join the study at a later time. You may also change your mind at any time to leave the study. This consent form will cover the time of the study (May 2014 to May 2016) or until you decide to change your consent.

If you give your consent you will be asked to complete questionnaires at the beginning of the research program and at the end of the program (2 years). You will be invited to take part in a one on one interview after every 6 months of the program or at the completion of your involvement with the program, whichever is earlier. If you withdraw from the program prior to completion you will also be invited to take part in a one on one interview.

What will I gain from participating?

The information from the anonymous questionnaires will be used to develop and improve the clinic, to inform your profession of the interprofessional process in a university teaching clinic, and develop your clinical skills by

ges

enhancing your interaction with other health professionals thereby improving your clinical education and patient outcomes. Co Health is evaluating this approach to health care and intends to implement the process at other clinics and will use the information gathered to assist in this process. Finally the data may be used to assist one of the investigators (Terri Dentry) in her PhD studies.

How will the information I give be used?

Data from the anonymous online questionnaires will be analysed using a variety of statistics to investigate the perceptions of clinical educators about interprofessional education. Individual responses to the questionnaire will only be seen by the researchers. Collated responses from the questionnaire will be used for peer-review publications in journals and for conferences.

What are the potential risks of participating in this project?

No particular risks are identified in participating in this project. The information provided will have no impact on your employment with Co Health and the responses provided to the questionnaires will be anonymous.

How will this project be conducted?

You will complete a questionnaire and be invited to participate in an interview at the end of the program (or at each 6 month interval as appropriate) about your perception of the treatment.

Who is conducting the study?

The Co Health Branching Out project in conjunction with Victoria University College of Sport and Exercise Science are organising this project.

Chief Investigator:
Associate Professor Andrew Stewart (Andrew.stewart@vu.edu.au)
Room L316 Footscray Park Campus
Tel: 9919 5200

Associate Investigators:

Dr Lyle Winton (lyle.winton@vu.edu.au)
Room S7101 Footscray Park Campus
Tel: 9919 9494

Dr Lauren Banting (Lauren.Banting@vu.edu.au)
Tel: 9919 4771

Student Researcher

Terri Dentry (PhD candidate & research student) (terri.dentry@vu.edu.au)
Room 4c236 St Albans
Tel: 9919 4705

If you wish to debrief about your involvement in this project, please contact Di McNamara (Psychologist) for a consultation at no charge to you. Please contact Di directly on 0411 634 309.

Any queries about your participation in this project may be directed to the Chief Investigator listed above.
If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001, email researchethics@vu.edu.au or phone (03) 9919 4781 or 4461.

Appendix D Practitioner consent form

VICTORIA UNIVERSITY
MELBOURNE AUSTRALIA

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH (clinician)

INFORMATION TO PARTICIPANTS:
We would like to invite you to be a part of a study: **Branching Out: Assessment of IPP model of care in Pain Management with clients from Asylum Seeker and Refugee backgrounds**.

You are asked to participate in this project by completing a set of questionnaires and consenting to participate in a one-on-one interview which will be audio recorded. The aim of this project is to assess the interprofessional education or the team approach to treatment in the clinic. The interviewer will conduct the recording process which can be started and stopped at any time. Any information from the recording will be kept anonymous and only viewed by the researchers. The research team do not feel there are any particular risks to you in this project. The practitioners involved with your case will also have agreed to participate in this project.

CERTIFICATION BY SUBJECT

I, (insert your name) .....

of (insert your suburb) .....

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study: **Branching Out: Assessment of IPP model of care in Pain Management with clients from Asylum Seeker and Refugee backgrounds** being conducted at Co Health and Victoria University by: Assoc Prof Andrew Stewart, Dr Lauren Banting, Dr Lyle Winton, & Melanie Block.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by:

(explaining researcher or clinician name) .....

and that I freely consent to participation involving the below mentioned procedures:

- Completing questionnaires about my perception of the interprofessional approach to treatment of pain management with clients from asylum seeker and refugee background
- Participating in a one-on-one interview with a researcher which will be audio recorded

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed: _____

Date: _____

Any queries about your participation in this project may be directed to the researcher
Associate Professor Andrew Stewart (9919 5200) or Melanie Block (8398-4277)

If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001, email Researchethics@vu.edu.au or phone (03) 9919 4781 or 4461.

V.1/2013 1 of 1

Appendix E Information provided to clients prior to starting care in the Branching Out program

WESTERN REGION HEALTH CENTRE HEALTH. WELLBEING. EVERYONE.

Program information sharing

The Pain and recovery service has been started to make our service better at helping our clients with pain and other problems. To do this a team of workers will work with you and will need to share important information about the work we are doing. We will not share any information other than what we need to for your treatment. We need to check with you that you agree to us; (tick box when you agree)

□ Writing shared notes on the computer which we can all read

□ Working with you to make a shared plan about how we can help you to improve your health/pain

□ Talking together about how you are going.

If any sensitive information comes up we will talk with you about how this is managed and you can let us know if there is particular information you do not want shared.

Evaluation

We would also like to evaluate whether our service is making a difference to our client's health.

To be a part of the study would like to check if you agree we can (tick box when you agree);

□ Go back to your file and collect information to study about changes in your health and pain that happen while you are in the program. This will not include your name.

□ Contact you at a later date to request an interview about your experience with the pain and recovery service

Do I have to be involved in the evaluation?

No. you can decide not to be involved and you can still go to our service and your treatment will be the same.

What will happen with the evaluation results?

We look at your results together with other people's results and see how we can improve the service. These results may be put in a project report, presented at conferences and published in journals. At no time will your name or other identifying information be used.

Appendix F Practitioner interview questions

Branching Out Program: Practitioner Interview questions (post initial questionnaire)

(Questions will be asked in an open format)

IPP definition:

> "IPP occurs when all members of the health service delivery team participate in the team's activities and rely on one another to accomplish common goals and improve health care delivery, thus improving patient's quality experience."

(AIPPEN: Australasian Interprofessional Education and Practice Association, accessed 11 September 2012. http://www.aippen.net)

1. Can you describe your thoughts and feelings about IPP in relation to the Branching Out project?
2. How do you feel yourself and the team will go in relation to effective communication? (prompts including active listening and expression of ideas?
3. What might be important to encourage this?
4. What are your thoughts about how ready the Branching Out team is to collaborate?
5. How do you think the team will merge the different perspectives or frameworks that team members operate in?
6. What are your thoughts and feelings about how the Branching Out team will work in relation to Roles and responsibilities between practitioners?

7. What may be important to enable the team to work through roles and responsibilities effectively?
8. Can you discuss how ready you feel the Branching Out team is to use an IPP approach with clients? (prompts using a team approach to assess the client's situation and include the client and relevant others in)
9. What might be important in developing this approach with clients?
10. Do you have any suggestions to ensure successful IPP practice in the Branching out program?
11. Do you have any suggestions in how to support new Branching Out team members to embrace IPP?
12. Do you have any other comments?

Appendix G Client interview questions

Interviewer will describe the Branching out program briefly, and reinforce that we want feedback to make our service better and to understand our client's experience

1. Can you tell us what it has been like for you being involved in the 'Branching out program'?

2. Can you tell us about anything you liked about the program?

3. Can you tell us about anything you didn't like' or wasn't good for you in relation to the program?

4. Can you describe anything you feel you have learnt during the program?

5. Has anything changed for you since you have been involved in the program? e.g. with your pain, coping, confidence, ability to do things. If so could you please share that with us?

6. Since you have been in the program has anything changed for you in the way you feel about your pain?

7. Do you do anything differently to manage your problems e.g. pain and stress compared to before you started the program. If so could you please share that with us?

8. What was the experience like for you working with a team of health workers (e.g. physio, Counsellor)?

9. Can you describe your experience with any written material that was given to you in the program? E.g. care plan, exercise sheet. Prompt-were they easy to understand?

10. What do you think could be done differently in this program to meet your needs and make the program better?

11. Is there anything else you would like to suggest to cohealth about meeting your health needs?

Appendix H Interpretative phenomenological analysis

Stage one: Multiple reading and making notes

The interview transcript is placed in the centre column with one line per row. On the left-hand column important words from the transcript are highlighted. One on the right-hand column the researcher's interpretations start to emerge.

	Stage 1 (practitioner's words)	Interview	Stage 2 (interpretation)
3			
4			
5			
6		(intro)	
7		M:	
8		Yeah, I guess I'm thinking of one. Where our skills of two practitioners	
9	complemented	complemented each other.	
10		Working with one of the clients so it was a session that I shared with one of the	
11		counselors xxx. And. So it's a client that we were working with and initially	
12	not keen to engage in counselling	the client we did the joint assessment together and he wasn't really keen to	client not keen on counselling from JST - even though Px could hear his need -12
13		engage in counseling. Despite us obviously identifying some contributing	
14		factors around the psychosocial that were contributing to his pain experience,	
15		but he agreed to engage in a session around, I guess pain education with the	Cx agreed to pain education - 15
16		felt tool so we work together with this client using the felt tool, but I think	
17		what was really like to me. The learning or the good thing about this was. I sort	
18		of came with my experience. I Suppose a bit more around pain Physiology in	Px both brought unique skills to the engagement - 18
19		the body. Peter had the experience around counseling and we were using the	
20		card to unpack or	
21		what are these different contributing experiences for the for the client as he	
22		kind of identified what the what the cards were that made sense to him and	

Stage two: Transforming notes into emergent themes

The second stage of analysis required the transformation of the information gathered from stage one into emergent themes. The focus of this stage was to look for meaning in the emergent themes and consider if the participant's words had an intention that was not fully articulated or hidden in the way it was said (Pietkiewicz and Smith, 2014).

(a) A synthesis of emerging interpretations from Stage two was done in chronological order. Line numbering was maintained from the original transcript.

Stage 3 (chronological synthesis)
client not keen on counselling to listening to both Px in JST - 12, 15, 24, 28, 38, 40, 53, 58
Practitioners brought unique skills that complimened each other to the engagement - 18, 52, 109
physio learning and appreciating counselling style of opening up the conversation, allowing clients to explore thinking and feeling more - 34, 50, 67
but - easy to revert back to your training - 68
the sum of you two together is greater than the whole - 111
each counsellor has their own style of questions, eg narrative style instead of open questions, identify client strengths from past to draw on skills to use in the present - 85, 96
applying new way of working with other clients - 77
Having GP's supporting the more flexible model was great to support and shape the experience for the clients - 125
sharing an understanding about pain, specific capacity building sessions - 152, 166
broadening scope of practice - counsellor will now talk to the client about pain instead of immediately referring - 161
having counsellors in the session providing comfort, different skills than your own, covering the risk in gap of scope of practice - 139, 143, 146
counsellors learnt more about what physio do than just the normal stereotype - 155
belonging, so much work but worthwhile, smile - 173, 174
brining and calling people to the IPP journey with you - 193, 194
Px on periphery, worried they were not included, difficult to find service times to match client needs - 197, 199, 202
Px at start helped to model the plan, involved in capacity building, difficult for those that came later - 202, 218, 221, 228
Some Px prefer structure and planning in sessions, personality type - 245
most of the sessions JST had more of a struction and an intention - worked out between the two Px - 255
if a JST for follow up it would be for a particular reason - so naturally discussed before with other PX on roles each will to meet the specified goals - 259

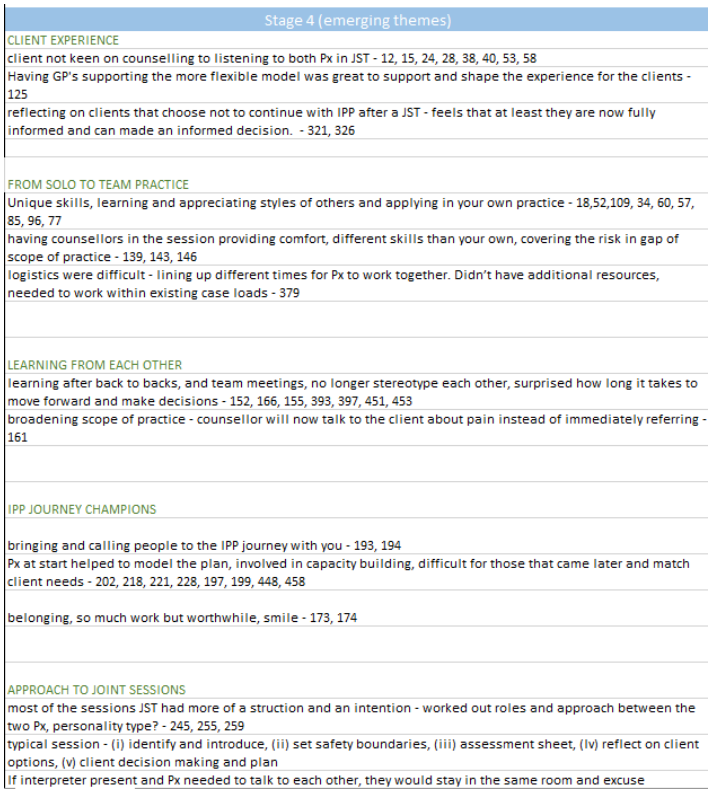
(b) Synthesis of the emerging themes was done across all themes and reordered.

Stage 3a (grouping synthesis)
Client experience
client not keen on counselling to listening to both Px in JST - 12, 15, 24, 28, 38, 40, 53, 58
Having GP's supporting the more flexible model was great to support and shape the experience for the clients - 125
reflecting on clients that choose not to continue with IPP after a JST - feels that at least they are now fully informed and can made an informed decision. - 321, 326
From solo to shared practice
Practitioners brought unique skills that complimened each other to the engagement - 18, 52, 109
physio learning and appreciating counselling style of opening up the conversation, allowing clients to explore thinking and feeling more - 34, 50, 67
but - easy to revert back to your training - 68
the sum of you two together is greater than the whole - 111
each counsellor has their own style of questions, eg narrative style instead of open questions, identify client strengths from past to draw on skills to use in the present - 85, 96
applying new way of working with other clients - 77
having counsellors in the session providing comfort, different skills than your own, covering the risk in gap of scope of practice - 139, 143, 146
logistics were difficult - lining up different times for Px to work together. Didn't have additional resources, needed to work within existing case loads - 379
Learning from each other
sharing an understanding about pain, specific capacity building sessions - 152, 166
counsellors learnt more about what physio do than just the normal stereotype - 155
collaborating after back to back sessions, hearing from others and adding your experience, expanding knowledge of the client - 393, 397

(c) Themes and subthemes for each individual case were finalised.

EXPANDING MY AWARENESS - FROM SOLO TO A TEAM PRACTICE
REFLECTING ON OWN PROFESSION
Understanding more about my own practice - 76, 166, 194, 97
EMPOWERING TEAM ON LEVEL OF STRUCTURE IN WORKING TOGETHER
Agree on level of structure - 24, 37, 48
Question responsibilities and clarity of roles - 331, 334, 170
BENEFITS OF WORKING TOGETHER
Learning to share with other professions - 239, 242, 245,
Illuminating different practice approaches - educator and facilitator - 156, 74
Trusting the team to expand my practice - 65, 197
BUILDING CONFIDENCE WITH NEW WAYS OF WORKING
from uncertain to familiar and confident - 30, 44
sharing final interpretation - 54
DEVELOPING NEW COMMUNICATION ROLES
engaged non-verbals with other professional - 51

(d) Synthesis of the emerging themes was done across all themes and reordered, into emerging super-ordinate themes.



Stage 4 (emerging themes)
CLIENT EXPERIENCE
client not keen on counselling to listening to both Px in JST - 12, 15, 24, 28, 38, 40, 53, 58
Having GP's supporting the more flexible model was great to support and shape the experience for the clients - 125
reflecting on clients that choose not to continue with IPP after a JST - feels that at least they are now fully informed and can made an informed decision. - 321, 326
FROM SOLO TO TEAM PRACTICE
Unique skills, learning and appreciating styles of others and applying in your own practice - 18,52,109, 34, 60, 57, 85, 96, 77
having counsellors in the session providing comfort, different skills than your own, covering the risk in gap of scope of practice - 139, 143, 146
logistics were difficult - lining up different times for Px to work together. Didn't have additional resources, needed to work within existing case loads - 379
LEARNING FROM EACH OTHER
learning after back to backs, and team meetings, no longer stereotype each other, surprised how long it takes to move forward and make decisions - 152, 166, 155, 393, 397, 451, 453
broadening scope of practice - counsellor will now talk to the client about pain instead of immediately referring - 161
IPP JOURNEY CHAMPIONS
bringing and calling people to the IPP journey with you - 193, 194
Px at start helped to model the plan, involved in capacity building, difficult for those that came later and match client needs - 202, 218, 221, 228, 197, 199, 448, 458
belonging, so much work but worthwhile, smile - 173, 174
APPROACH TO JOINT SESSIONS
most of the sessions JST had more of a struction and an intention - worked out roles and approach between the two Px, personality type? - 245, 255, 259
typical session - (i) identify and introduce, (ii) set safety boundaries, (iii) assessment sheet, (Iv) reflect on client options, (v) client decision making and plan
If interpreter present and Px needed to talk to each other, they would stay in the same room and excuse

Stage three: Across case clustering of themes

This stage of analysis required clustering themes across participants, which involved developing a master spreadsheet of themes from each interview to determine how they related to each other visually.

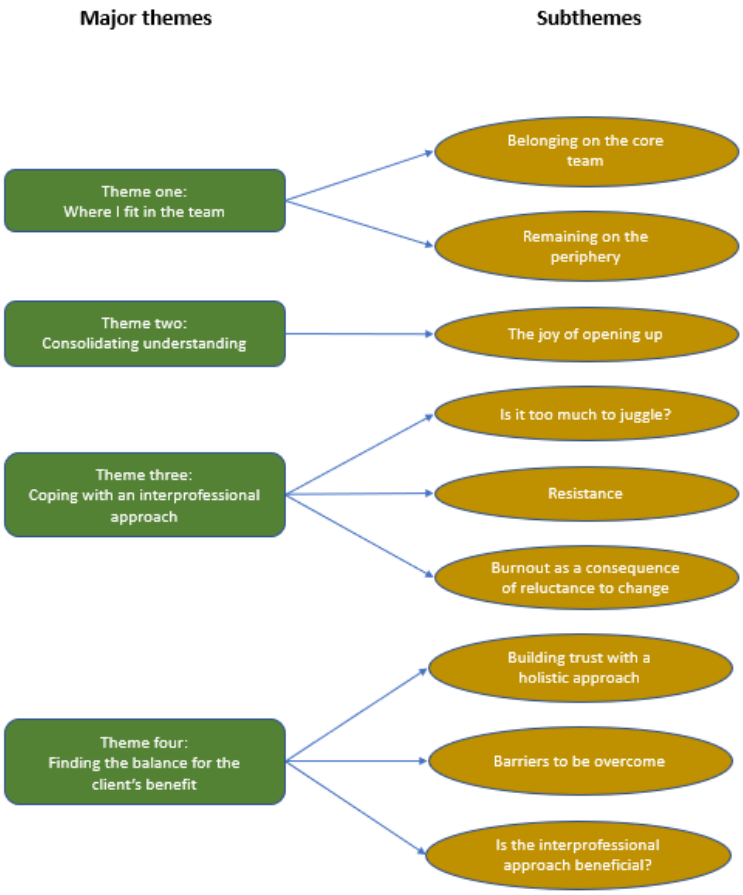
Major themes from each case were aligned and super-ordinate themes started to emerge. Analysis and interpretation were complete commonality was found among the themes. The themes were then reduced into final superordinate and subthemes.

Changing how I work from solo to team practice					
BUILDING CONFIDENCE WITH NEW WAYS OF WORKING	from uncertain to familiar and confident - 30, 44	sharing final interpretation - 54			
DEVELOPING NEW COMMUNICATION ROLES	engaged non-verbals with other professional - 51				
BRANCHING OUT PROCESS	Program is time consuming, once a month for intial sessions but each client takes a lot of time - 78, 83, 348, 355	Program is different from expected, some good, some bad - interesting - 95			
FROM SOLO TO TEAM PRACTICE	appreciating collegiatity, examples of reaching out and supporting each other, seeing relief on team members face when provide support - 131, 145, 147, 220	BO - takes unexpected directions - so that's part of the interest - 149	counsellors being emotionally supportive for the physios - 154	admitting physical clinical info - all double dutch to me - 215	
POOLING INFORMATION	pooling info gives diff perspectives of client needs, changes how you work with more info, saves time - 263, 273, 274	pooled info mix of therpeutic conversation, education, crisis management, case work, each session different - 279, 280			
CROSS COLLABORATION WITH OTHER PRACTITIONERS	more aware of collaborating, different to past actions - 312, 313, 314,	more familiar with team, not worried about asking for help or another opinion - 320, 324, 333			
COORDINATING TEAM PRACTICE WITH CLIENTS	client who prefer two appointments on same day, takes more time to coordinate, is good for practitioners if it can happen - 263, 365, 367, 368				
GREATER FORMS OF COMMUNICATION	client consent to share info opens up communication channels back and forth - 21, 27, 39, 36, 197				
FROM INDIVIDUAL WORKING TO TEAMWORKING	concerns about training, client sessions, team meetings, informal communication will be too time consuming, unable to fit with current case loads - (sally 1) 7,133, 138, 140, 142, 147 (sally 2) 98, 101, 103	reflecting on allocation of once a month, instead of weekly, has not lined up with client needs - 11, 25, 30 (sally 2)	concerned about complex teamwork on case loads, stretching and overwhelming on individuals - 45, 48, 49, 50 (sally 1)	questions intake - if client needs physio can counselling be done later - 89, 91 (sally 2)	
UNDERSTANDING MORE ABOUT HOW THE PROGRAM WORKS	Appreciating the program has a burden to run it - 23, 28, 30, 32, 36, 39	IT system is barrier for counsellors but ok for physios (direct access to GPs) - 41, 46, 50, 53	management looking at new structure for counsellors - will be embedded in teams - not quite like BO but better than what it is now on their own - 138, 160, 161, 162,	need to keep chipping away at the program - needs to be easier to roll out - best practice not available but would help - 261, 262	
WORKING WITH OTHER PRACTITIONERS IN THE PROGRAM	wanting to address issues on the spot but more practitioners on the team makes it harder - 15	if we are all working together (same time) people have respect and express their perspectives well - 16, 17, 22, 65	we are doing different things but we are not in each others way - 40, 41		
INFORMAL COMMUNICATION	communication informal in corridor - valuable to pass on info about client to other BO practitioners - 183, 190				

Stage four – Reporting findings

An overview of the major (super-ordinate) themes and subthemes was provided for the practitioners and clients so that the reader is able to navigate the findings easily. The reporting of findings started with the first major theme, the subthemes of the first theme, and then moved through the remaining themes one by one. Evidence from the original transcripts was provided to highlight the major findings of each subtheme, indicating the interview it was derived from with line numbers for verification.

Diagram of major themes and subthemes



Kyra's story

Amanda notices Kyra coming towards her in the corridor. She has not worked with Kyra before but recognises her from the staff photos on the wall. She looks younger than Amanda expected. Kyra looks up, and in doing so drops her folder of paperwork from her hand. Amanda looks at the paper on the floor and Kyra frantically putting them back into some order. Kyra has clean white shoes and those exceptionally glossy nails that you can only achieve by paying someone else to do them for you.

Kyra smiles an awkward smile and asks rhetorically, "you must be Amanda?" Before waiting for an answer, Kyra asks if they can spend a few minutes together before their joint client session at 11am to "*go through a few things first*". Amanda agrees and sets off again to her office to finish some paperwork before her next meeting.

At 10:50 Kyra walks into the scheduled clinical room, hoping Amanda realised she meant that they should meet here before the client arrives. Amanda walks in just a few seconds later, and they chat quickly. "*I'll lead and start with my usual assessment list until question 6*", says Kyra, and Amanda agrees that she will take over with her questions from that point. They agree to go back and forth in a semi-structured way between their usual processes. Then the call comes through from reception that their client is waiting. Amanda leaves to collect the client from the waiting room and escort him back into the clinical meeting room.

Kyra looks around the room and wonders where they will all sit. There will be four of them; herself, Amanda, the client, and an interpreter. She shuffles the chairs

from where the last practitioner left them in the room into a position she feels will work the best. Kyra is still worried. In her mind, she is trying to memorise the first six questions so that she doesn't need to look at the assessment sheet.

Kyra checks over things that worry her. It's a lot to ask of the client. To come into such a small space and be bombarded by questions from two practitioners. How will he cope? He doesn't speak English and has never been in a clinical session with a counsellor before. Moreover, we are talking to him about pain and trauma. Kyra wanted to lead. She is relieved Amanda agreed to that part at least. Kyra will take it gently for him. She will ask some easy practical questions about his physical pain first. That will help to make it feel more like a normal session.

Another worry flashes through her mind. How will she cope in front of the more experienced Amanda? She certainly doesn't want to come across as not capable. Anxiety swells up in her throat.

Amanda returns with the client and the interpreter. They slip quickly into the seats as Kyra points to where she feels they will be the most comfortable. Kyra starts by introducing herself and allows Amanda to do the same. They run through some safety points. He is okay to ask them to stop anytime. Everything is confidential. He doesn't need to answer their questions or give them any details he is not comfortable with. He nods. The interpreter says "*Yes, he understands*".

Thirty minutes later, Amanda notes how jovial Kyra is. So different from this morning. She is sitting back in her chair and laughing at his remarks. They are smiling at each other. Kyra nods to Amanda and leans closer towards her. She asks, "*what would happen, if you changed it around the other way?"* Amanda

thinks for a moment and answers Kyra's question. The interpreter conveys both the question and answer to the client, and he nods back. "*Thank you*", he says.

As they prepare to leave the room ninety minutes later, the client wants to add one more thing. He talks at some length with the interpreter. The interpreter thinks for a moment before translating the comments. He says, "*You have made me feel special. Others have not validated my pain before. They don't listen. But you have listened*".

The meaning of the story

Kyra over prepares so she doesn't feel awkward in front of Amanda – but in fact she enjoys the session and learns new things

Kyra is worried the client will be overwhelmed and surprised but instead they feel validated

This story says that preparation and process quell anxiety, and clients can gain benefits from being in a situation that is different from what they are usually in

The themes

Practitioner Anxiety, preparation, structure leads to less pressure, fun, asking questions just for the hell of it

Client Overwhelming for the client leads to client feeling validated

Appendix J Abstracts accepted for conference presentation

New Zealand Interprofessional Practice (NZIPP), held August 2016

Branching Out - A holistic program to assist people of refugee and asylum seeker background to move beyond pain

The “Branching Out’ program is a cohealth IPP pilot program which has been running since January 2014. The ‘Branching Out’ program is a team of staff who views pain as a complex human experience and works in a collaborative and client centred way to assist in their understanding of pain and pain management strategies. We support the client to look at new opportunities in life and build on their existing resources. We work in a culturally safe way and acknowledge the impact torture and trauma and settlement experiences may have on our client’s health and wellbeing.

Background

Pain is a significant issue for people of Refugee and Asylum Seeker background. Current concepts of pain emphasise the multi-dimensional nature of the human pain experience and evidence has identified strong associations between pain and re-experiencing trauma. Those experiencing pain can access a range of primary health services, however, these are often not delivered in an integrated way. The Branching Out project was developed in a community health setting to address these factors.

Description

This action research project began in September 2012 and involved a literature review, staff survey (current practice and knowledge) and qualitative research in relation to client perspectives and beliefs about pain and service experience. The data collected informed the development of a model of interdisciplinary practice. This model is currently being implemented alongside staff capacity building activities.

Lessons Learned

There is very limited evidence specifically relating to the management of pain in Refugee and Asylum Seekers in primary health care. There are however, important principles which can guide this work.

Client interviews revealed complex and intertwined factors contributing to their individual pain experience including past trauma, current stress, physical health, and current settlement issues including visa conditions of Asylum Seekers. Clients reported the therapist and client connection, in addition to expertise, were the most important features of quality care.

Shared experience, learning and the development of trust have been important factors in enabling clients and therapists to work together to identify the contributing factors to the client's pain experience and develop a personalised service response for each individual.

Next steps

This project has resulted in a significant change in how staff support people of Refugee and Asylum Seeker background with pain. Ongoing evaluation will

provide information about the effectiveness of the Branching Out model from the client perspective and inform future development of service provision.

All Together Better Health IX (ATBHIX), held November 2016

Branching Out: Implications for enhanced client advocacy through joint sessions as part of an interprofessional practice program

Dentry T[1]., Block M[2]., Zion D[3]., and Stewart A.M[1].

Background

Many people of refugee and asylum seeker background experience complex health problems on arrival to Australia. Chronic pain is one such prevalent problem. Branching Out is a program utilizing an innovative approach to the difficult issue of chronic pain that employs Interprofessional practice (IPP) principles to reinforce the team structure built around the client to support change in key domains contributing to their pain experience. We utilized relational ethics as a framework for exploring issues related to teamwork, care, and autonomy of patients within this setting.

Objectives

The objectives of the Branching Out program were to invigorate the client's quality of life by helping them to engage in an integrated manner with psychological, physical and social factors, thereby improving their self-determination, connectedness and wellbeing.

Methods

The program consisted of an initial joint session with the client, two different practitioners and interpreter if required. On conclusion of the initial session the client decided to follow the IPP program pathway or single service pathway. Nine clients who graduated from the IPP program pathway and nine practitioners were interviewed pre and post the program intervention.

Outcomes

Client outcomes included moving better, having less pain, feeling in control, and feeling informed. Many clients had gained an understanding of the link between their own physical pain and psychological distress and felt better able to cope with these symptoms when they presented.

We found that practitioners provided 3 different and innovative ways of demonstrating advocacy through the IPP setting.

1. Simplifying language
2. Picking up on missed referrals
3. Identifying needs and actioning them.

Implications

An ethics of care has at its core that individual autonomy is socially dependent. Therefore, the relationships that clients develop with their team, rather than with a single practitioner, are fundamental to their return to health.

Keywords:

Relational ethics, client advocacy, interprofessional practice

1. Victoria University, College of Sport and Exercise Science and Institute of Sport, Exercise and Active Living (ISEAL)
2. cohealth, Refugee and Asylum Seeker Health program
3. Victoria University, Office of the PVC (Research and Research Training)