

**Interprofessional Collaborative Practices Enhance the Overall Benefits of Mental Health  
Services Provided to Counselling Clients**

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CPC 695: Counselling Psychology: Research Project, School of Health and Social Sciences

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December 30, 2025

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Interprofessional collaborative practices involve practitioners working with others outside of their profession to ensure their clients' concerns are properly managed (Manspeaker & Hankemeier, 2019). In Canada, psychologists have only recently begun to join interprofessional teams due to the increased concerns of mental health complexities and the College of Alberta's changes to incorporate more collaborative efforts (Gaboury et al., 2011). Due to this shift in interprofessional collaboration efforts, it is essential to ask questions about the effectiveness of interprofessional collaboration practice in mental health. Therefore, this research paper will aim to answer two questions about the use of interprofessional collaboration practices for psychologists. Firstly, the main research question proposed is: Can psychologists participating in interprofessional collaborative practices enhance the overall benefits of mental health services provided to counselling clients? The secondary research question proposed is whether interprofessional collaborative practice can also be effective in private practices? These questions are relevant to the field of psychology, as this literature will show that when psychologists use interprofessional collaboration efforts, it improves clients' access to care, faster diagnosis, and fewer clinical mistakes (Truelove et al., 2023). External resources, such as community resources or medical professionals, can be used to collaborate to provide the most effective care to clients. Since it is a psychologist's ethical standard to provide effective care to clients, clinicians need to have a network of resources to allow for a collaborative care approach to therapy (Canadian Psychological Association [CPA], 2017).

Siloed health care was the main understanding of health up until the past two decades (Lau et al., 2024). Siloed systems focus solely within their profession, focusing only on what's in

their scope of practice. This isolates practitioners in being knowledgeable within their field of practice rather than viewing health through a holistic lens (Goodwin et al., 2016). The holistic health approach looks at all aspects of a person's health, such as mental, physical, environmental, and societal (Saylor, 2004). Recently, there has been a shift in researchers and practitioners taking a collaborative or integrated approach to health care to take pressure off an overwhelmed health care system (Greidanus et al., 2020). Practical experience research shows that the links between physical and mental health often correlate with overall health effects, yet still, the approach is often to treat these aspects separately (Weishut et al., 2024). The goal of this research would be to highlight the importance of psychologists incorporating interprofessional collaborative health approaches to allow for collaborative treatments that benefit overall client health.

### **Self-Positioning Statement**

My goal in choosing the topic of interprofessional collaborative practice within mental health is to promote awareness of these practices and the impact they can make on clients' overall health. Since I want this literature research paper to create a positive impact, I must ensure that I remain as unbiased as possible by presenting the facts within my research rather than my own opinion. This impact of assessing my biases comes from the reflexive practice of epistemology, which helps ensure my paper's validity stays intact (Alejandro, 2021). It is important to write reflexively as this creates an ongoing practice of self-reflection while engaging in my research (Greschke, 2024).

My hopes for this research review are that the psychology community will be able to understand the value and importance of interprofessional collaboration as an expansion of competency. The reasoning behind my hope is due to my position from both a personal and

professional standpoint of aligning with interprofessional collaborative practices. I aim to achieve my hope for industry understanding by diversifying my research to ensure a saturation of research while effectively analyzing key information regarding strengths, weaknesses, and understanding of interprofessional collaboration. This research practice ensures I am following the socio-political practice of reflexivity by including all knowledge as discourse found within my research findings (Alejandro, 2021).

### **Personal Interest**

My personal interest in choosing this topic comes from my previous work in a non-profit organization that used interprofessional collaborative practices (IPCP). This previous work experience introduced me to using IPCP to get the best care, support, and services for clients. I was also in a practicum placement that used interprofessional collaboration practices. My interest within the field of psychology is to work with public organizations due to my belief that appropriate care should be available to all people. This accessibility can be increased due to the benefits of interprofessional collaborative care, allowing for easier referral processes, community connections, and collaboration with clients and other practitioners in a way that benefits clients' overall health (Mian et al., 2012).

Interprofessional collaborative practice also helps match clients to what best fits their needs, such as connecting low-income populations to community or free services (Mian et al., 2012). This can also create access for rural communities that may not have services within their towns. This topic is of personal interest to me as I have grown up in both big cities and small towns, which has shown me that even though mental health care may be easier to find in bigger cities, getting access to these services can still be a challenge.

## **Professional Interest**

As mentioned above, my professional interest has been that I have worked in non-profit/public professional services before and have enjoyed the overall supportive collaborative process. In my professional experience, I worked with homeless individuals, as well as low-income First Nation families. Due to the clientele, I worked with having a lot of complex needs, the importance of interprofessional collaboration was high to ensure clients were receiving adequate support for their concerns. I would like to continue working within the public side of the psychological field once I graduate to help make mental health more accessible. I am aware that public mental health organizations already operate within interprofessional collaborative practices, due to co-location, making it easier for multiple professional disciplines to collaborate on patients they are seeing (Greidanus et al., 2020). This also allows for an easy referral process that may still include wait times due to availability, but does not create wait times for the referral process (Mian et al., 2012)

Where a professional interest lies outside of public health services is the incorporation of more private practices working within an interprofessional collaborative scope. Psychologists entering private practice due to the increased autonomy and financial benefits can be less likely to interact with other interprofessional disciplines (Greidanus et al., 2020). Based on the literature below, there has been evidence to suggest that interprofessional collaborative practices could create better overall health results for clients, thus increasing the view of competency of their therapist. As mentioned previously, IPCP can also allow for easier referrals, which can sometimes be a process for doctors to refer out to private practices for therapy if private practices make themselves open to collaboration (Mian et al., 2012). This can account for an increase in profits and clientele for private practices. Private practitioners could also become more involved

in community events or organizations to offer community support while getting referrals for clients. Therefore, there is an argument that while interprofessional collaboration can help clients' overall health, it can also have financial benefits for practitioners who operate within interprofessional collaborative practice either remotely or co-locationally.

### **Mitigating Biases**

It would first be important to acknowledge the possible biases that I may have when it comes to the topic of the importance of interprofessional collaborative practices. Professionals should acknowledge biases as they can harm our research and the points we aim to make (Herz et al., 2020). Within scientific practice, the expectation is to report on the findings rather than to fit findings to our research, as this can create unreliable data (Siedlok & Hibbert, 2014). My biases include those mentioned above, which are: my previous/current work in interprofessional collaborative practices, passion for working with low-income/diverse clientele, having a holistic health approach, and my experience witnessing the effectiveness of interprofessional/interagency collaboration.

With these biases being outlined, it is also important to note that for my paper to be ethically sound, I am doing the work to ensure that my paper is as unbiased as possible. This involves the inclusion of the drawbacks of interprofessional collaborative practices, as well as seeking regular support from my capstone supervisor, participating in collaborative feedback with capstone group members to engage in other perspectives, journaling my ideas, reflecting on my positioning, ensuring I take regular breaks, and making sure that my research is done to the point of oversaturation to where I can no longer find papers saying anything new. These

processes will allow me to ensure that I have not only thoroughly researched my topic but also that I am not holding a biased perspective throughout my paper.

### **Proposed Methods**

This research overview will look at qualitative, quantitative, case, and mixed-method research studies within the past five to twenty years, with some exceptions for older relevant research that discusses IPCP enhancing clients' overall mental health through collaborative health practices. This research literature review will seek sources from the City University of Seattle main library, as well as include specialized databases such as PsycINFO and the research library. There will also be sources collected from Google Scholar and from references used within the papers in my literature review. All sources used will be peer-reviewed to fit APA guidelines.

Due to this literature review's inclusion of multiple methods of research literature from a broad range of sources, the approach this literature review will take is a narrative approach (Efron & Ravid, 2019). Within the narrative approach, the broad range of resources collected will be condensed into the main themes of this literature review, which are: identifying collaboration, identifying interprofessional collaborative practices (IPCP), the benefits of IPCP, the drawbacks of IPCP, and what IPCP means for psychologists. An issue with using the narrative approach is that it is often viewed as less systematic and scientific; thus, it does not gain as much support from the scientific community. Due to the research question being a social and social science issue, it is fitting that the approach would use a pluralistic approach to capture the societal nature of the research rather than focus on a systematic review. Due to this topic of literature research being conducted on the integration of collaboration among professionals, it seems fitting to have the approach to the review also hold the same standards as the narrative approach does.

## **Summary of Self-Positioning**

Since I have previous experience working within interprofessional collaborative workplaces, I have a perception of their benefits to clients' overall well-being. While this is my potential bias, I aim to have this study be a scholarly representation of the facts for how psychologists' use of interprofessional collaboration can create benefits for their clients and themselves. This will be done through the use of peer-reviewed scholarly sources that will be analyzed and summarized within this paper. To mitigate biases, I aim to be consistently reflexive through my paper by journaling and utilizing other perspectives to ensure I address both the positive and negative aspects of interprofessional collaboration as it pertains to psychologists.

## **Literature Review**

### **Holistic Health Approach**

Before diving into collaborative practices, it is first important to understand the use of a holistic health approach (sometimes labelled integrated health). As defined in the introduction, the holistic health approach looks at all aspects of a person's health, such as mental, physical, environmental, and societal (Saylor, 2004). The term holistic is derived from Eastern understandings of balance and circular movement of life, rather than siloed sections of health more commonly used within Western ideas of health. Holistic environmental factors that can be overlooked in siloed health, such as the impacts of location, finances, and quality of life (Kaczmarek et al., 2024). A model of holistic approach that represents Eastern cultural perspectives of health and balance of energy is the Circle of Health (Saylor, 2004). This model looks at physical, mental, and spiritual aspects that contribute to health, along with incorporating the balancing concept of yin and yang to balance recovery with activity to create a centralized

concept of overall wellbeing. While this approach is derived from cultural beliefs, it can be adapted to different cultural understandings by focusing on the common values of rest, activity, and well-being. Additional models that derive their approach within a holistic health lens will be discussed in the models of collaboration section of this literature review.

### **Collaborative Practices**

Collaborative practices are defined as practitioners providing a combined care approach to combat complex client needs with other professionals to provide effective person-centred care (Truelove et al., 2023). When clients are provided with the right support from clinicians, it allows for cost-effective care for clients. Collaboration within counselling is already a mandatory requirement based on the College of Alberta Psychologists (2023) standards of practice. This standard of practice acknowledges that counsellors must be held accountable for the quality of care they provide through supervision or consultation. Psychologists are primed for collaborative practices due to the brevity of their work, allowing them to collaborate with multiple professions (Greidanus et al., 2020). Even though psychologists have a skill set that allows them to be collaborative partners, they are often not taught effective collaboration skills such as group work, group reflection, group conflict resolution, group communication and consistent group collaboration (Greidanus & Fox, 2024). Collaborative care can take various forms, including interprofessional teams, co-location collaboration, remote collaboration, and interprofessional collaborative education. These will all be defined within the primary literature review of this paper. It is also important to note that collaboration and interprofessional collaboration can be used synonymously within research, which can confuse the public's understanding of how collaboration efforts differ. This synonymous definition will be discussed further in the recommendations for future research section of this paper.

While collaborative care practices have been of international interest for a few decades, collaborative mental health has only been more recently gained momentum to be researched and implemented into practice (Greidanus & Fox, 2024). In 2013, the World Health Organization created the Mental Health Action Plan to support the need for collaborative practice in all forms of care. This plan puts an emphasis on mental health involvement with community-based organizations and interprofessional collaborative (IPC) approaches, which allows clients access to integrated health care. Literature reviews conducted by Greidanus and Fox (2024), found that there is increased evidence that collaborative practice in mental health “improved quality of services, enhanced support professional receives, improved access/delivery of mental health care, increased service to rural areas, decreased societal/individual costs over time, and contributed to positive patient outcomes” (pg.1). These literature review findings corroborate findings found in other research studies and literature reviews used in this paper. Despite evidence for the benefits of collaborative practice and the call from researchers for psychologists to participate in more collaborative practice, Canada is not one of the leaders in collaborative practice. The Canadian Psychological Association (2017) has realized the impact that collaboration between professions can have, which led them to add training competencies for interprofessional practice.

### **Interprofessional Collaborative Practices**

The interprofessional collaborative practice (IPCP) is a shared decision-making and communicative process between resources to provide effective care and positive client outcomes (Manspecker & Hankemeier, 2019). The earliest documented IPCP in healthcare dates to the 1900’s although the increased use of IPCP didn’t happen until after the Second World War (Gaboury et al., 2011). IPCP for psychologists was first discussed by Macfarlane (1950), who

argued that psychologists could be used to enhance the medical care practices (Goodwin et al, 2016). Decades later, Hinshaw and DeLeon (1995) pushed for psychologists to participate in IPCP, although this incorporation still did not make it into the 2011 Core Competencies for Interprofessional Collaborative Practice, as psychologists were left out of IPCP. Also in 2011, the Canadian Psychiatric Association and College of Family Physicians created a joint paper supporting the collaborative idea of shared care of mental health practitioners in teams with family physicians (Heath & Holmqvist, 2017). Psychologists did not start being considered for IPCP until two years later, in 2013, as the rise of biopsychosocial models became more popular for understanding holistic healthcare (Goodwin et al, 2016). There was an early attempt to incorporate interprofessional collaboration practice in health care by the Canadian government through the “Romanow and Commission of the Future of Health Care in Canada (2002), LeBreton and Kirby (2001), and Mazankowski (2001) reports” (p.2). Even with a push for collaborative efforts, a survey of Canadian psychiatrists and psychologists conducted by Lee et al. (2012) found two two-thirds of survey participants reported a lack of collaborative opportunities to integrate collaborative care practices. The interest in IPCP over the past two decades could be explained by the increase in client complexities combined with rising health care costs (Gaboury et al., 2011).

Interprofessional collaborative practices are important to the growth of psychological practices, as psychology has been siloed due to the previous siloed health care system. To incorporate specialized learning, psychologists have created their own silos within the field of specialized care, which can lead to distance or barriers within the field as it can decrease collaborative efforts (Arredondo et al., 2004). When we silo professions, we end up limiting our understanding of interactive factors on clients' overall health. Psychologists are seen as

impressionists of clients' mental states through examination of clients' emotions, relational spaces, and inner experiences, while physicians create client impressions from examination of their bodies (Weishut et al., 2024). While this differentiation of practice skills is important when considering who clients should seek services from when experiencing bodily or mental harm, it also diminishes the interconnectedness of professions and psychologists' skills, thus decreasing collaborative efforts. Therefore, interprofessional collaborative practices rely on holistic care approaches, as this allows for collaborators to use their specialized skills while also using their interconnected skill sets, and knowing when collaborative efforts are needed to ensure proper care (Lau et al., 2024).

Wait times to see specialists in Canada are growing, with a range of two to six months (Truelove et al., 2023). Interprofessional collaborative care can be used to improve access to care while limiting duplication of services. Interdisciplinary practice is also going beyond client collaborations, as there has been an increase in interdisciplinary research (Holmqvist et al., 2019). Interdisciplinary research both supports collaborative efforts while also approaching research in a more holistic way, which could reduce research gaps in inclusivity. Interdisciplinary research will be discussed more within the future research recommendations section of this paper.

Psychologists should understand that interprofessional collaboration practices show benefits to patients' overall health success when all aspects of their health are considered. This research shows the need for private psychology practitioners to incorporate interprofessional collaborative practices into research and allow for similar support for client health as co-location collaboration of public services such as hospitals and schools (Greidanus et al., 2020). A qualitative literature review conducted by Greidanus et al., (2020) found that many of the studies

reviewed found positive results by participating in collaboration practices. These positives were noted as better collaborative results, increased medical compliance, effective treatment follow-up, additional savings, and flexibility of collaborative practices. In contrast, siloed health care systems can create barriers due to the lack of communication between professionals working with the same client, mistrust in other professionals, isolation, and duplication of care (Lau et al., 2024).

Integrated care within IPCP includes “health education, prevention, overall wellness promotion, relapse prevention, and support for adaptive functioning through treatment” (Truelove et al., 2023, p. 81). Integrated care collaboration can help with the early identification of client risks of psychotic illnesses. When mental health professionals participate in integrated care within primary care professions, there have been noted benefits found, such as early detection, appropriate treatment, recovery support, and lessening of illness recurrence. Integrated interprofessional collaborative practice with community-based organizations encourages social understanding and factors to be acknowledged in the best treatment outcomes.

Based on an overview of research studies on interprofessional collaborative practice (IPCP), five common themes were discovered in IPCP, which are: shared philosophy, location, frequent communication, team dynamics, and finances (Weishut et al., 2024). When discussing power/hierarchy, the assumption stated by Weishut et al. (2024) review is that physicians adopt leadership in collaborative efforts due to differences in power, such as salary and influence/status. While power and hierarchy can be important to leading groups, this can also be a tension point for the autonomy of individual practitioners. Therefore, while establishing some form of leadership can be helpful in IPC teams for effective work on client care, it is important that all members of teams have an opportunity to grow and have input; otherwise, this can lead to

more desire to be independent rather than to collaborate. Rich et al. (2021) study found major themes as distinguishing factors that influence IPCP, which are professional, systemic, and client levels. Systemic factors that influence IPCP are interprofessional exposure, location, availability of services, and accessing psychologists in the private sector for referrals. Professional factors that influence IPCP are interpersonal dynamics, role understanding, professional perspectives and priorities. Client factors that influence IPCP service costs, consent, and the affordability of additional services.

### **Co-location collaboration**

Co-location collaborative processes are defined as interprofessional practices that operate out of the same location (Greidanus et al., 2020). Interprofessional collaborative practices are most easily created and maintained when located in the same place, as they allow for a familiar and non-stigmatizing location for clients to access multiple services (Craven & Bland, 2006). Examples of co-location collaboration are hospitals or offices/buildings that intentionally include interprofessional practices within the same geographical location. Co-location practices easily enhance collaborative practices as communication and referrals are made easier for both practitioners and clients (Mian et al., 2012).

An area in which an increase in need for interprofessional collaboration due to co-location accessibility is within schools to counteract decreased resources and non-academic barriers that affect academic performance (Mellin et al., 2010). Schools that provide mental health supports tend to bridge mental health gaps as well as promote accessibility of services to children in communities (Lyons et al., 2024). School mental health (SMH) staff have been used to help address inequities against racial and ethnic families in multiple ways through reduced logistical barriers, system approaches to promote mental health, and teaching/practicing skills

that support general mental health skills in schools. Although there is promise for SMH services bridging mental health gaps for youth and their families, there are still barriers within this approach. These barriers include proper training, workforce shortages, routine work without deepening understanding of cultural diversity skills, and a limited budget for accessing professional/continuing professional education. For SMH to be effective, it's important that they do not work in isolation but with teachers and the school itself. If the collaboration isn't present, students, teachers, and these professionals will not be able to benefit fully from the use of IPCP.

### **Non-colocation/Remote Collaboration**

Non-colocation collaboration allows private practices or rural practitioners/community resources to collaborate with others outside of their practice or city (Heath et al., 2008). This is important as rural communities often lack mental health supports of community resources, which puts them at risk for worsening mental health symptoms. Rural communities, when compared to more urban communities, have “higher rates of unemployment and mortality rates, lower economic status, higher rates of chronic illness, limited diversified health care, and more difficulties with transportation, which offer less access to health care overall” (Goodwin et al., 2016, p. 181). Smaller towns can also mean a downsizing of healthcare systems, causing a need for greater travel to seek care, which is something that is often seen in rural First Nations communities. It also means that services provided in rural spaces could face friction within ethical codes, due to dual relationship concerns, which will be discussed more in the ethics section of this paper (CPA, 2017). While ethical codes allow for these dual relationships in rural areas due to the need for care, the use of telehealth services allows people to access therapy outside of their geographical location, which allows for more accessibility. This is why there is a demand for interprofessional mental health collaborative practice to meet the needs of rural and

northern communities in Canada (Goodwin et al, 2016). Due to the demand needed in rural communities, there is an opportunity for psychologists in private practice to collaborate with small-town communities to offer services, especially with the rise of telehealth services.

While many collaborative practices use co-location to effectively provide collaborative care, such as in hospital settings, due to the increase in telehealth services during COVID-19, co-location is no longer a requirement for effective collaboration (Truelove et al., 2023). This means private psychology practices could more easily integrate off-site interprofessional collaborative practices while maintaining their autonomy. Individual autonomy is important for both clients and practitioners as all parties must be able to have input in the care they give/receive (College of Alberta Psychologists, 2023). Private practitioners who work with collaborative teams can help to reach additional clients from services in rural areas where mental health access is limited or from community-based organizations. These services can be provided through telehealth care while also combining telehealth collaboration among interprofessional collaboration teams.

As mentioned, telemedicine allows for improved mental health services for rural and underserved populations (Truelove et al., 2023). Telemedicine can involve the use of telephones, video conferences, and remote patient monitoring. Clients can use telemedicine to communicate with health care professionals, but it can also be used to help mental health professionals collaborate with each other. Telemedicine interprofessional collaboration practices reduce barriers such as location or transportation for case conferences and shared appointments with clients (Tan et al., 2023). Therapists who utilize telecommunication for client care and for interprofessional collaboration ensure that clients get access to integrated care opportunities to support complex clients. The use of virtual care becomes an important part of current and future

health care studies as it can begin to address non-colocation collaborative needs, as well as equitable access to technology and virtual care.

Within the context of technological development in health care, electronic health records (EHR) are used to support collaboration, shared decision-making, and coordinating patient care (Vos et al., 2020). EHRs allow practitioners with access to these files to instantly view clients' medical history, relevant information, and testing results. EHRs are used mainly by co-located collaborative teams, such as hospitals, due to the collaborative nature of these settings. When working in non-co-located collaboration teams, electronic health records are recommended due to their effective nature for allowing access to multiple professionals (Greidanus et al., 2020). Due to practical and ethical concerns of having electronic health records that can be accessed by multiple professionals, this requires professionals to revise their consent forms to ensure clients understand the possible ethical implications of using electronic health records and professional collaboration (Calman et al., 2012). These ethical concerns will be addressed in depth in the ethics section of this paper.

### **Benefits of Interprofessional Collaborative Practices**

The benefits of IPCP, as mentioned above, are enhancing client care through collaboration, opportunities for clinicians to work as part of a healthcare team, shared responsibility, shared accountability, effective clinical problem-solving, collaborative care plans, and appropriate referral practices. These practices are also beneficial to clients who may have difficulties navigating the hoops of the medical system, either financially or systemically (Reist et al., 2022). The cost and accessibility of care are key factors when clients seek out mental health and medical services, as due to increases in living costs, more people are struggling to

afford everyday life, let alone have additional finances to pay for counsellors or medical care (Flores, 2025).

The benefits of interprofessional collaboration have been noted to show “improved outcomes for clients, client satisfaction, job satisfaction for professionals, colleague support, and manageable workloads” (Rich et al., 2021, p. 683). While psychologists' input in interprofessional teams has been found to indicate positive outcomes for clients and healthcare teams, psychologists are still underrepresented in interprofessional collaboration studies. Studies reviewed by Rich et al. (2021) found that the inclusion of psychologists in IPCP led to increased finances, lower hospital readmission rates, and reduced consultation wait times. Psychologists can aid in helping health care professionals understand clients' psychosocial context/environment and maximize therapeutic alliances with team members and clients. This contribution helps reduce overall consultation time due to the psychologist's knowledge in multiple areas.

An additional benefit for psychologists to take up IPCP is the impact that this practice has on clinicians' secondary traumatic stress and compassion fatigue responses. Mental health professionals show high rates of secondary traumatic stress and compassion fatigue, which leads to negative effects such as burnout, lower job satisfaction, hypersensitivity, isolating tendencies, and health issues (Strolin-Goltzman et al., 2024). Strolin-Goltzman et al., (2024) found that effective leadership and interprofessional collaboration were found to be protective factors for mental health workers against secondary traumatic stress and compassion fatigue. Effective leadership allowed professionals to have clear goals and support during workplace challenges. While interprofessional collaboration helped professionals to feel a lessened workload and improved their perception of time for tasks.

## **Drawbacks of Interprofessional Collaborative Practices**

The drawback of IPCP is that each member of a collaborative team still operates as an individual. This may limit the collaborative nature of interprofessional work as it can create problems with team cohesion due to health care operating from siloed systems (Lau et al., 2024). These drawbacks could be found to cause friction between ideals of care philosophy and professional identity, and cause biases in resources. Collaborative practices often also have initial burdens of cost to the practice, as there will need to be implementation of IPCP education for all staff, collaborative booking systems, collaborative files, and online systems that can be accessed by all members of the IPCP team (Reist et al., 2022). While this may be an initial drawback, Reist et al. (2022) found that in all studied cases of collaborative care, the financial drawback was only in the initial stage of setup, but would later be financially beneficial to collaborators and to clients once practices started.

Factors that can challenge interprofessional collaboration stem from systemic factors that have limited collaborative opportunities with other professionals (Rich et al., 2021). These limiting systemic factors include a lack of collaborative training, a lack of opportunities for IPC, a lack of resources, and incompatible professions. Some unique barriers that can arise during counsellors' sessions using collaborative practice methods can be that: “counsellors are not seen as equal collaborators, time needed for collaboration, agency separation, and need for workplace culture shifts from a siloed mentality to collaborative (Greidanus et al., 2020). Due to the drawbacks mentioned, it would be important for IPCP teams to be a diverse group of people from multiple care backgrounds with similar values and goals to eliminate collaboration overlap and conflicting professional ideals.

To further highlight the challenges of IPCP, a comparative study between Belgium and Canada was conducted by Chomienne et al. (2015). Belgium is in its beginning stages of collaborative practice compared to Canada's more developed efforts of IPC (Weishut et al., 2024). Although Canada has participated in IPC longer than Belgium, Canada still faces difficulties with being open to IPC, especially with its later start to mental health incorporation (Chomienne et al., 2015). Belgium has also been changing its own understanding of psychologists' work, as psychologists were not used in hospital settings until 1974 and up until forty years ago, only administered intelligence and personality testing. Although there have been differences in the timelines of psychology acceptance in health care between Belgium and Canada, both countries have struggled to fully incorporate IPC as professional identity struggles and arguments over mind-body health have set back IPC progress (Weishut et al., 2024). Therefore, if psychologists cannot carve out their place in collaborative settings or collaborative settings do not adhere to holistic health principles, it challenges the effectiveness and openness of psychologists joining IPC.

### **Interprofessional Education**

Interprofessional Education (IPE) is a structured educational practice designed to create learning experiences for diverse professions within the healthcare field (Ward et al., 2018). These learned experiences derive from combined knowledge from these diverse health care fields, alongside skills of collaborative practice. These shared knowledge activities allow for the exploration of misconceptions, reduction of stereotypes, enhance professional respect, recognize other professions' skills, and prepare for effective collaboration. Interprofessional collaborative programs are used not only as a way for professionals to collaborate but also allow for collaborative skills between clients and their families, allowing for coordinated care. Oandasan

and Reeves (2005a & 2005b) believe that interprofessional education is successful when all participants learn with evidence-based educational theory, problem-solving learning, reflective practice, experiential learning and practice within a safe environment. Experiential learning allows students to integrate knowledge from the course into real-world examples. The use of experiential learning showed an enhancement in students' client-centred care, work with clients' families, and client advocacy skills (Nguyen et al., 2022). By incorporating modelling, learning information, and then practicing information, participants in IPEC programs reported being more likely to use the knowledge and skills they learned up to a year later.

When the Interprofessional Education Collaborative (IPEC) program core competencies were first created in 2011, it was developed by six health profession organizations; psychology was not one of the organizations included at the time (Ward et al., 2018). The input of psychology and two other health professions was added to an updated IPEC in 2016. By 2016, more than sixty professions participated in the creation of IPEC institutes. This collective participation increased interest in the need for interprofessional collaborative practices. The core competencies of IPEC consist of four categories for collaborative practice: shared values, role definition/overlap, team dynamics, and communication. Psychologists are desired in leadership roles for IPEC institutes as they play a large role in creating consensus and developing a shared vision amongst diverse professions. Since psychologists work within evidence-based practice, they are also desirable for helping to create IPEC programs. Psychology programs' own teachings of active learning experiences, such as debriefing, small group discussion, role play, and observational feedback, are useful in improving IPEC learning.

## **Challenges with Interprofessional Education Programs**

Interprofessional Education Collaborative (IPEC) programs can have logistical, administrative, technical, and financial challenges (Ward et al., 2018). Even when programs understand the value and have a desire to promote effective IPEC programs, it can be difficult to coordinate the joining of students from various programs for joint collaborative learning. There can also be the barrier of facility space when factoring in spaces needed for an additional program to be held on campuses. Issues regarding faculty payment and tuition fund distribution can also arise when fitting in an additional program to campuses. Another challenge faced by IPEC programs is that they must combat siloed health care thinking (Church et al., 2009). This is a challenge since most IPEC programs take place at higher levels of education after students have learned and worked in siloed systems. If students align with siloed systems, it is difficult to create buy-in for collaborative efforts.

Phillips et al. (2016) research showed that IPEC programs that did not include diverse professionals faced a decrease in interprofessional understanding, resource sharing, and networking. Increases found in higher referral sharing were found to apply only to specialized professionals. Phillips et al. (2016) did find that it was easier for professionals to collaborate when they worked with similar insurances or programs. While there was an increase in skills of mindfulness and motivational interviewing being used by other professionals who were not in mental health, no other skills seemed to be adopted. Therefore, their findings argue that it is not enough to just put diverse professionals in learning settings together, but instead programs must be specific on common goals, outcomes, skills, and resources to be shared for an overall educational impact for collaborative efforts.

## **Theoretical Frameworks**

When looking at the research on interprofessional collaboration (IPC) practices, six models stood out as theory incorporation in IPC practices. These models are the biopsychosocial model, the internal classification of functioning model, the collaborative care model, the person-centred model, the polyculturalism model, and the interprofessional collaboration supervision model. These models have various aspects that contribute to the successful practice of IPC by focusing on factors such as holistic health, personalized care for clients, and collaboration skills.

### ***The Biopsychosocial Model***

The biopsychosocial approach to mental health is the integration of different perspectives from different disciplines on collaborative care (Lee et al., 2012). This perspective considers social, biological, and psychological factors in the client's mental health. Collaboration within the biopsychosocial lens believes that interdisciplinary care shows more benefits for public care, especially when involving mental health concerns, as this creates holistic care. Similar to the biopsychosocial model, the medical home model looks to treat clients as a whole; therefore, primary physicians aim to incorporate their offices with collaboration for other healthcare professionals (McClain et al., 2024). With this model, physicians partner with clients and their families to establish their care needs, then use those needs to identify collaborating practitioners to meet the clients' needs. Due to increases in mental health concerns after COVID-19, physicians are looking to collaborate more with psychologists and community programs to meet clients' complex needs.

### ***Internal Classification of Functioning Model***

Another model recommended for interprofessional use is the International Classification of Functioning (ICF) (Johnson et al., 2020). ICF is used to define, measure, and create health policy. The ICF model uses the “etiology of function and disability with specific health conditions, personal factors, social factors, and environmental factors” (pg. 87). This model follows a holistic lens, just like the biopsychosocial model, as holistic health care is the push for interprofessional collaboration. Interprofessional students who can learn ICF and apply it to their future work can enhance their cultural perspective of health and function within health and disability scopes.

### ***Collaborative Care Model***

The Collaborative Care Model (CoCM) is an evidence-based practice used in primary care settings to improve patient outcomes, satisfaction across psychiatric conditions, and collaboration (Reist et al., 2022). In Reist et al, (2022) narrative review, CoCM was found to play a crucial role in increasing clients' access to proper mental health treatment. CoCM improves access to behavioural health services in settings where physical health is also accessed and improves overall clinical outcomes. The five key elements needed to achieve these benefits are “population-based care, care management, measurement-based care, brief evidence-based psychotherapy, and psychiatric consultation” (Reist et al., 2022, pg.1). Clients who were treated with a collaborative care plan were diagnosed and treated within six months 75% of the time, compared to non-collaborative care, which was 25%. Clients' experience with CoCM allows clients to improve due to trusted professionals who assist in treatment, reduction of stigma, and reduce non-compliance with treatments. CoCM is also highly adaptable to concerns of specific populations, underserved communities, and mental health issues that have been historically

difficult to diagnose and treat, such as women's health or substance abuse, for example. Treatments are then selected to optimize client access and treatment outcomes. Since CoCM uses measurement-based care and screening tools to ensure the effectiveness of client treatment received, it provides evidence-based material, but also allows clients to be a part of their treatment journey. With this model, professionals need to be trained in CoCM skills through interprofessional collaborative education, which would be an additional cost, but these are skills that professionals can use throughout their careers.

### ***Person Centred Care Model***

Therapists can also improve IPC practices due to their work in cultural adaptation of theories (Johnson et al., 2021). This is also done through person-centred approaches as treatment can be tailored to clients' needs that could affect their care (Tudor, 2022). Person-centred therapy from Carl Rogers focuses on creating connected relationships that avoid prejudices and instead allow for clients' autonomy and collaboration in their care (Ring, 2009). This form of therapy also helps strengthen the relationship between practitioners and clients, which is the most effective part of treatment success (Tudor, 2022, & Johnson et al., 2021). In working with a person-centred lens, psychologists open themselves to partnering with clients and their families to understand clients' unique needs, culture, and preferred methods (McClain et al., 2024).

### ***Polyculturalism Model***

When looking at a cultural approach to IPC, Rosenthal, & Levy (2012) suggested the use of a polyculturalist approach. Polyculturalism is used to describe a willingness to collaborate, acknowledging differences of knowledge, and an ability to critique one's own traditions. This perspective allows practitioners not to just focus on differences but instead to understand how

other practices can interact and influence their own work. This can be done through encouraging curiosity and exploration of other professions. Psychologists who can understand how their practice can intersect with other professions allow themselves more opportunity for career growth, stronger collaboration, create a network of resources, and expansion of competency.

### ***Interprofessional Collaboration Supervision Model***

When considering that the education of collaborative practices increases the desire to collaborate, as well as teaching the skills for future collaboration, it is important to consider how supervision aids in this learning. Effective supervision should provide trainees with opportunities to learn and practice collaborative skills with other professionals, such as communication, proper patient care, trust, and evaluation of IPCP impact (Mathis & Lamparyk, 2025). The Interprofessional Collaboration Supervision Model (IPCSM) operates under the belief that psychology trainees learn developmentally, which requires supervision to evolve to incorporate interpersonal processes with IPCP. It is also important that supervisors teach trainees to gauge how much IPCP is needed for patients, as the patients need to determine the amount of professional interactions needed. Supervision is meant to model practices for trainees; therefore, it is important for supervisors to show effective IPCP. This modelling would show effective/frequent communication, trust, and understanding of other professionals. By integrating IPCSM into supervision practices, there can be an enhancement in team cohesion, accounting for individual needs with collective needs, and patient-care outcomes.

### **Measurements of Collaboration**

To help provide validity for IPCP incorporation, two main measurements were found within this literature research, which are Bronstein's (2002) Index of Interdisciplinary

Collaboration (IIC) questionnaire and Goreczny et al. (2015) Team Process Assessment (TPA). Bronstein (2002) created the Index of Interdisciplinary Collaboration (IIC) questionnaire to measure social workers' perceptions of interprofessional collaboration. These questions were based on Bronstein's five elements of interprofessional collaboration. The five elements of interprofessional collaboration as described by Bronstein (2003) were interdependence (interactions with other professionals to complete goals), flexibility (deliberate blurring of professional roles to help work collectively), collective ownership of goals (shared responsibility), reflection on process (reflection of the process of collaboration), and newly created professional activities (programs or structures created for accomplishing collaborative goals). Moderate support was found for these five elements of interprofessional collaboration based on Cronbach's alpha and factor analysis (Mellin et al., 2010). Findings from Mellin et al., (2010) study, which looked at measurement tools which can be used in schools to measure mental health collaboration, found that Bronstein's measurement could be used to create a brief tool. This brief tool would be the 26-item IIC-ESMH. The IIC-ESMH measures four of the five elements found in interprofessional collaboration, which are related to ESMH literature, which are reflection of process, flexibility, newly created professional activities, and interdependence. When measuring ESMH teams' findings of this measurement found moderate to high internal consistency for the four elements listed. Collective ownership was not found to be a factor of interprofessional collaboration in school mental health settings due to families not being seen as professional collaborators.

Another measurement tool used to assess IPC teams is the Goreczny et al. (2015) Team Process Assessment (TPA). TPA measures team function and dynamics across nine areas of IPC effectiveness (Henderson et al., 2023). These nine areas include "generating ideas for problem

solutions, participating in the identification of problems, developing relevant/measurable goals, implementing strategies, sensitivity to diversity concerns, positive approaches, respecting others during differences of opinion, providing an overall rating of team function, and being a respectful consumer” (pg. 973). The TPA is particularly useful in measuring the effectiveness of complex technical assistance teams who are IPC teams working with clients who have complex physical and behavioural concerns (Goreczny et al., 2015). This effectiveness is measured through surveys and Likert scale questions to measure inter-rater reliability. Luiselli (2015) also suggested that feedback could be used as a social validity assessment for IPC efforts. Feedback is already a part of many standards of practice codes, including the College of Alberta Psychologists (2023), as feedback is part of continued competency. Feedback within collaborative teams allows for an opportunity to align with core principles of ethical codes/ collaboration, help improve best outcomes for mutual clients, and improve interprofessional relationships (Luiselli, 2015).

### **Summary of Literature Review**

Interprofessional collaborative practices (IPCP) stem from holistic health care approaches, which look at all aspects of a client’s health (Saylor, 2004). IPCP creates opportunities for practitioners to work with other professionals outside of their industry for improved client health outcomes. This can be done through co-location or non-co-location. Co-location services can also help clients who may feel stigmatized by their community or family members due to cultural beliefs about mental health, as a building with multiple resources can allow clients to be more discreet about the services they are seeking, as well as more accessible (Mian et al., 2012). Making mental health more accessible helps clients be able to address mental health concerns rather than focusing on immediate issues only due to financial constraints

(Flores, 2025). Along with reducing costs to health care providers and clients, interprofessional collaboration has been associated with shorter inpatient stays and faster diagnoses (Rich et al., 2021). Due to advancements in technology, practitioners can still work collaboratively in non-co-located spaces due to telehealth services and electronic health records, which allow for easier access for rural communities. Interprofessional collaboration education programs work to teach collaborative skills that can be used to increase effective IPCP (Ward et al., 2018). Six models within this research help structure IPCP, which are the biopsychosocial model, the internal classification of functioning model, the collaborative care model, the person-centred model, the polyculturalism model, and the interprofessional collaboration supervision model. To help provide validity for IPCP incorporation, the two main measurements within this literature research are Bronstein's (2002) Index of Interdisciplinary Collaboration (IIC) questionnaire and Goreczny et al. (2015) Team Process Assessment (TPA). While there is support for the effectiveness of IPCP, some challenges include initial costs, interprofessional conflicts, and concerns over ethical codes (Reist et al., 2022).

### **Research Proposal**

This literature review provides evidence that interprofessional collaboration helps clients' overall mental health support, although this topic of research in terms of psychology is still limited, since CAP only started implementing the need for collaboration in 2016 (Goodwin et al, 2016). This review has shown that the health care model is switching to a more biopsychosocial lens, which supports the importance of research examining the benefits of interprofessional collaboration for clients and professionals. My second research question, that private practices can also benefit themselves and their clients with collaborative practice, isn't as researched and supported due to the literature findings above showing that interprofessional collaborative

practice isn't often taught or acted upon in private spaces (Lindblad, 2021). This shows the need for private practice collaboration, but also for professionals in private practice to participate in research on interprofessional collaboration.

My proposed study is an exploratory qualitative research study using comparative interviews from psychologists collaborating with other professionals in a collaborative setting (hospitals/non-profits/community, or government organizations) compared to collaborating psychologists in private practice. This comparison would be done through responses of narrative interviews and select surveys, with participants being recruited through email practices or posting on Alberta psychologists' Facebook group. The rationale for an exploratory qualitative research study is due to the complex nature of interprofessional collaboration and due to the limited research available for interprofessional collaboration with a focus on psychologists. This research aims to create a unified perception of the benefits of interprofessional collaboration (IPC) among collaborators and their clients, as this concept is still debated amongst practitioners (Mitchell & Boyle, 2015). While the literature supports its positive effects, perceptions are still working to be shifted to the same positivity.

## **Measures**

Data for this research would be collected through interviews and short-form questionnaires conducted before the interviews. The questionnaires used will be Brodhead et al. (2018) self-evaluation Competence and Confidence Checklist (CCC), and Woo et al, (2018) short version of the Professional Identity Scale in Counselling (PISC-S). The CCC is used by professionals to evaluate their feelings of competency when working on areas outside their usual scope. This is important for understanding participants' feelings towards collaboration efforts. The PISC-S measures engagement in counselling, attitudes toward counselling, competency, and

knowledge, which would be useful to assess participating psychologists' competency in their work. This is important due to the personal professional perceptions' role in effective collaboration efforts.

## **Methodology**

The interview will be semi-constructed with direct questions about questionnaire responses, but the majority of questions will be a narrative approach to allow participants to openly discuss their experiences with interprofessional collaborations (IPC). The narrative approach allows participants to assert their own autonomy of opinion within this study and helps limit researcher bias. To ensure this unbiased response, the researcher must not share their viewpoint on IPC. Instead, researchers must conduct these surveys and interviews to assess psychologists' experience with IPC, even though the research questions/hypotheses assume an overall benefit of mental health for clients/ professional experience.

## **Participants and Sample Size**

Participants of this study would be provisional or registered psychologists who have worked in the field for a minimum of two years, who work with IPC practices either in colocation or non-colocation. Participants will be from both private and collective practices, working with adults (18+) in Alberta, have consent to discuss general overall themes/results of clients they've worked with (no identifying information, just overall results), and who work with complex clients, as this works best for IPC. It will be important for inclusivity that psychologists come from diverse cultures, genders, and ethnicities. This is important to the study as many other research studies examine mainly Caucasian psychologists, which limits the generalization of findings. This could also be expanded by having psychologists who work with a diverse

clientele. For the sample size of the research study, the aim would be for twenty-five participants from public settings and twenty-five from private settings. While this sample size would be considered small for most research studies, this sample size is due to narrative components being more time-consuming and due to the perceived difficulty of finding a similar number of private practice psychologists participating in IPC. A similar number is needed for the comparative approach, as both sides should be equal to create a balanced finding between both sectors. While this comparison wouldn't have statistical significance due to the sample size and narrative approach, the findings of this study would be important for a few reasons. Firstly, this study would show private sector psychologists participating in IPC. Secondly, this study could look at psychologists' understanding of the effects IPC has had on their clients' overall mental health. Lastly, this study could show a comparison of the benefits and challenges of IPC from the private and public sectors. This last point would be important for future research, as the literature currently available focuses the majority of IPC research on public/co-located psychologists.

### **Inclusion and Exclusion Criteria**

In selecting the fifty participants inclusion criteria would be provisional or registered psychologists who have worked for at least two years with a diverse group of clientele. The psychologists will have worked collaboratively either co-locationally or in private practices. Participants will need to have worked collaboratively with other professionals at least twice within the past year to ensure recent relevant data. Participants must also be from diverse backgrounds to ensure the participant sample is able to be generalized.

Participants will be excluded from the study if they are unable to complete the interview or questionnaires. Participants will also be excluded if they have not been in good ethical standing with CAP. Participants will be excluded from the study if they have any strong biases

that could drastically alter the study. Participants will be excluded if they do not have consent to discuss client outcomes from interprofessional collaborative practices.

### **Limitations and Justifications**

A limitation of surveying and interviewing psychologists on the benefit of IPC rather than clients would be that there could be a risk of information not being accurate or related to clients' true experiences. This risk, however, poses less of a risk than gaining access to psychologists' clients who have been treated through IPC, as this would take considerably more time and pose more ethical concerns about confidentiality. While some may argue that by not including psychologists' clients in the study, the validity of clients' overall mental health improvements would be in question. Two reasons to justify this decision would be to limit harm, which is a requirement in both psychology and research, and secondly, it can be argued that the psychologists would have a significant understanding of client improvement due to the amount of time they've spent with clients, the therapeutic relationship, observed change, and any measurements used to assess change although this also depends on clients feeling of alliance with their therapist (Pace et al., 2021). Concerns about confidentiality can also be mitigated by ensuring that psychologists have clients' consent to share the outcomes clients received from interprofessional collaborative (IPC) practices. This confidentiality would outline that only relevant information about the client's experience and basic demographic information would be used, but no identifying information or personal information not related to IPC practice would be shared.

### **Assumptions, Delimitations, Limitations, and Scope**

The assumption of the study would be that psychologists working with IPC would have more benefits to clients' overall mental health progress and professional benefits from IPC than they would have negatives. Delimitations would be psychologists who don't work with IPC, haven't worked with IPC in the past year, and psychologists working with only children, as this could cause complications with consent. Limitations could be a limited number of psychologists in the private sector participating, limited response to surveys, limitations of Alberta psychologists to make the study relevant and within CAP guidelines, and counsellors who wouldn't be able to discuss overall client outcomes due to consent. The scope of this study would be Alberta psychologists, working with adults (18+), and working with or in IPC, either colocation or non-colocation.

### **Summary of Research Proposal**

The proposed research study of a comparative narrative study between psychologists in co-located and non-co-located practices who have used interprofessional collaborative practice (IPCP) in the last year will be designed to test whether psychologists find benefits for themselves and their clients while using IPCP. It is a comparative narrative study due to my secondary question of whether IPCP is beneficial to private practitioners. The questionnaires used alongside narrative interviews are Brodhead et al. (2018) self-evaluation Competence and Confidence Checklist (CCC), and Woo et al, (2018) short version of the Professional Identity Scale in Counselling (PISC-S). All fifty participants will be psychologists who have been practicing for at least two years in Alberta and who follow the inclusion and exclusion criteria. This study assumes that there are improvements for psychologists and their clients when participating in IPCP.

## Implications for Counselling

Interdisciplinary work practices are meant to integrate data, skills, and theoretical principles of diverse professions in a collaborative way that addresses complex concerns of clients (Kwan & Hung, 2025). With the rise of case complexity due to an increase in biopsychosocial stressors, psychologists must stay in the loop of their clients' growing needs. Interprofessional collaboration allows for more innovative practices as diverse professionals can work together to create unique health plans for their clients. Embracing interprofessional practices can help increase professional competency, allow for broadened areas of work, and help to acquire new skill sets, which can increase accessibility to more clientele (Johnson & Mahan, 2019).

Psychologists are positioned to thrive within interprofessional collaborative practices due to humanistic practices, counselling skills, and ethical codes of practice (Johnson et al., 2021). In looking at school psychologists, IPCP Hopple & Ball (2023) showed that interprofessional collaboration improved the quality of service provided to school children and increased psychologists' and children's ability to cope with stressful situations. When looking at IPC teams in hospital settings, clients are seen to have improved health outcomes, a reduction in health harm, shortened stays, and improved alliances between professionals and clients/families (Montesano & Scherb, 2023).

Although psychologists have skills that allow them to be effective collaborators, there are barriers to IPCP effectiveness. When looking at common collaboration between psychologists and social workers, Avant & Swerdlik (2016) found barriers of time and training to collaborative efforts. Other issues that have been found in IPC that would affect psychologists' collaboration

efforts could be a lack of finances for IPC, miscommunication with unshared language, concerns around client confidentiality, and client access to services (Chenneville et al., 2024).

### **Psychologists Professional Identity**

When looking at psychologists' professional identity, the term of disciplinary centrism is defined as when a professional becomes stuck in a narrow and biased focus because of over-reliance on their own discipline (Kwan & Hung, 2025). This centrism not only limits care received by their clients but also limits collaboration practices that could benefit both practitioner and client. This view can also cause research or theories from other fields to be overlooked. These biases can also cause harm when practitioners need to work collaboratively, as the openness for collaboration will not be in place, which will cause such interactions to be ineffective and possibly harm potential relationships with other professionals. These harmed relationships contribute to discipline silos and to limited referral practices.

While there is a fear of losing professional identity in collaborating with other professions, there is support that collaboration can increase professional identities and create new mental health perspectives, which would benefit psychologists' work (Johnson & Mahan, 2019). Having a sense of professional identity is important, but if we focus too much on interprofessional differences instead of connecting aspects, it can lead to professional isolation (Kwan & Hung, 2025).

To better understand professional identity, Woo et al, (2018) created a shortened version of the Professional Identity Scale in Counselling, which is known as PISC-S. The PISC-S is only sixteen items with four subscales compared to the original, which is sixty-two items with six subscales (Klein & Beeson, 2022). The four subscales measured in the PISC-S are: engagement

in counselling, attitudes toward counselling, competency, and knowledge. Klein & Beeson (2022) found that intraprofessional identity was noted as strong by all participants. Participants were able to have a strong sense of professional identity even while collaborating with other professions. The lowest score was found when looking at professional advocacy, which indicated that while counsellors had a strong sense of identity, they often didn't advocate for their profession. This finding shows that advocacy is not only important for our clients but also for our profession, as psychologists need to advocate for their place and importance in interprofessional collaboration efforts.

### **Professional Perspectives of IPC**

To assess psychiatrists' and psychologists' experience with interprofessional collaboration, Lee et al. (2012) collected survey data from 1040 psychologists and 267 psychiatrists across Canada. The data from this survey showed that many autonomous professionals from both fields showed familiarity and willingness for interprofessional collaboration. This study found that while participants had learned about interprofessional collaboration in their training, most participants hadn't sought out this collaboration until later in their careers. Lee et al. (2012) study suggests a need for better training on interprofessional collaboration and correction of misunderstandings about how to seek out external collaboration. Another study by Church et al. (2009) found that doctoral students (59%) were almost twice as likely to have collaborated with other professionals compared to master's students (31%). This corroborates other research in which most IPE efforts have been conducted at a doctoral level.

## **Advocacy**

A part of a psychologist's role is to be an advocate for our clients and the community they serve (College of Alberta Psychologists, 2023). Psychologists who work in the public sector can witness policies or systemic structures that can create challenges for their clients, in which being an advocate for their clients is needed for quality client care (Allbaugh, 2020). IPC helps with advocacy efforts, as collaborative networks create access to quality care for clients while also allowing interprofessional support for advocacy efforts. IPC advocacy work to reduce social injustices and works to bridge the gap of health disparities in our systems. Psychologists could also look to join advocacy groups to support collaborative practices and social justice goals, even if they chose not to collaborate within their private practices.

## **Summary of Implications for Practice**

Implications of IPCP for psychologists are based on three main themes of professional identity, professional perspective, and advocacy efforts. Professional identity is important to maintain professional boundaries, but shouldn't be used to isolate oneself from working with other professionals (Kwan & Hung, 2025). The professional perspective looks at how psychologists are trained to work with others and how they implement that training to be able to work collaboratively (Lee et al., 2012). Lastly, advocacy looks at client advocacy in collaboration, but also for psychologists to advocate for the importance of their contribution to IPCP (Allbaugh, 2020).

## **Recommendations for Practice**

### **Moving Away from Siloed Systems**

Siloed professional care systems create barriers to research and treatment innovation as only a singular profession's perspective is considered (Lau et al., 2024). Siloed mentality limits communication within internal systems and with external resources, as siloed systems focus within their own scope, which could lead to missed opportunities for additional support needed in complex cases. Psychologists are useful in moving from siloed care to collaborative care systems, as there is overlap of interprofessional teachings in their courses (Lindblad, 2021). Psychologists are also taught to consult with supervisors and colleagues to discuss best practices for client cases. This skill encourages the incorporation of other perspectives and working with others for a common goal.

### **Usefulness of IPC Incorporation**

Interprofessional collaboration has been found to support telehealth services expansions, promotion of professional advocacy, support for social justice, sustaining quality accessible health care, and addressing the complexities of the work of therapists (Klein & Beeson, 2022). This means that by supporting interprofessional collaboration, psychologists can continue to show their importance in the health field and in advocating for support for their profession and clients. By creating a group identity, interprofessional teams can create an environment of shared values and goals that promote benefits overall professional effectiveness (Schwartz & Conklin, 2015).

## Referrals

Clients can often receive fast additional support with direct referrals between providers (Mian et al., 2012). Bidirectional referrals can also benefit psychologists, as their efforts to collaborate with other professionals can ensure mutual referrals back. This can be more of a benefit for those in private practices, as close collaboration with other professionals can allow for more referrals with limited advertising costs. While physicians or other health care providers may provide unidirectional referrals to psychologists without mutual referrals back, a key factor to continued referrals is communication. Communication within the referral process provides more confidence in referral choices and a greater willingness to collaborate over time.

Psychologists looking to increase their collaborative care can benefit from collaborating with primary care physicians through increased communication between professions (Pidano et al., 2018). Increased communication between physicians and psychologists has created more direct referrals. These referrals increase when communication between physicians and psychologists remains consistent. Physicians in Pidano et al., (2018) surveys were happy to work with psychologists, but often didn't hear back after referrals were made, which caused irritation, as this dynamic seems one-sided. If psychologists in private practice can make continuous efforts to collaborate with doctors on patients, share relevant information for treatment, and help with mutual education, this could lead to a consistent referral flow. This referral flow is a benefit to clients' holistic health and creates a financial incentive for psychologists in private practice to also be interested in collaborative care.

## Need for IPEC Training

Interprofessional education for collaborative approaches takes a universal approach to health care, and the desire for learning shows that psychologists also need to support the movement of collaboration with other health care professionals (Ward et al., 2018). When looking at IPEC, it would be important to incorporate more connections in courses that have overlapping disciplinary knowledge (Kwan & Hung, 2025). This incorporation allows students in these classes to begin to understand how professions can share knowledge that is useful to multiple professions and could be used to promote future collaboration.

Interprofessional collaboration education (IPCE) programs stem from Allport's (1954) intergroup contact theory. His theory believed that unified groups that work equally towards a common goal with support from authority and each other will reduce prejudice and increase appreciation. Hewstone and Brown (1986), who added to Allport's theory by suggesting that group members should be positive, believe that group members represent their respective fields, and understand where group members' skills overlap and where there are differences. Other additions and changes to Allport's original theory have been made, such as groups needing some form of leadership for collaboration. Yet intergroup contact theory holds true in IPCE as students are taught to effectively communicate, have understanding/respect for other professionals, and share knowledge, all to work towards common goals that benefit their clients (Jones, 2017). IPEC creates competencies within common, intraprofessional, and interprofessional scopes (Vereen et al., 2018). By increasing competencies in areas of personal and interpersonal facets, psychologists can provide effective, holistic care to their clients. This also works on reducing stigma against other professionals.

For IPEC to be effective in overcoming collaborative barriers, faculty members must be knowledgeable about interprofessional collaboration as they will be models for students' collaborative efforts (Johnson et al., 2004). It is also important for schools to show the relevance of IPEC and how this expansion of knowledge can affect the greater community. Psychologists' role in overcoming collaborative barriers within education requires their participation as faculty, collaborators in IPEC curricula, and in the advocacy of IPEC (Pan et al., 2022). Since psychologists have skills that can create effective collaboration, more psychologists should get involved in educating or supporting the education of future students in collaborative work. A recommendation for IPEC is the inclusion of real client scenarios or real-life interactions with clients in training settings, as this not only allows student to practice their learning but also shows client concerns such as social isolation (Romme et al., 2020). Through this practice, clients can also share their feedback on what is helpful in collaborative care and what isn't, which would also be helpful for future research.

### **IPC for Private Practice**

While most of the research conducted on IPC focuses on co-located settings, a lot of collaborative need and practice is used in private practices, as not all clients seek mental or physical health support in hospitals (Montesano & Scherb, 2023 & Leventhal et al., 2021). Private practices often allow clients to have more relational support from their practitioner, which creates a safe and trusting environment. This safe space allows private psychologists to collaborate with their patients to find suitable recommendations for interprofessional referrals or correspondence. When clients trust their psychologists in discussing concerns with other professionals, this allows all professionals working with the client to operate more effectively, rather than in a system of missing information.

For IPCP to work effectively in non-co-located spaces, systems need to be set up for ethical collaborations for the betterment of clients' mental health. This can be done through creating collaboration among professions that share similar ethical codes, creating secure shared documentation files, and providing more training for professionals to learn other professions' ethical codes (Johnson et al., 2021). This would require those within private practices in interdisciplinary roles to actively seek out resources and collaborative partners based on client needs. For example, if a psychologist works with women who have experienced trauma, they may need to have interdisciplinary collaboration with psychiatrists, doctors, social workers, and with community resources that work with women, such as CASA or Sagesse. While clients can search for these resources themselves, there can often be barriers or a lack of understanding on how to navigate these supports (McClain et al., 2024).

### **Summary Practice Recommendations**

The recommendations for psychologists incorporating more IPCP are for moving away from siloed systems, seeing the usefulness of incorporating IPCP, the use of referrals for IPCP, IPCP training, and IPC for private practices. By moving away from siloed health care to incorporated care, clients receive quality health care while psychologists gain additional support (Schwartz & Conklin, 2015). This support also benefits psychologists financially through increased referral processes, which benefit private practices (Mian et al., 2012). By incorporating more collaborative training for psychologists, they can use these skills to establish collaborative connections that further career longevity and financial benefit (Kwan & Hung, 2025).

### **Fundamental Next Steps for Research**

Research on psychologists' participation in interprofessional collaboration (IPC) efforts, research is limited. While the Canadian Psychological Association (CAP) has advocated for more psychology inclusion in collaboration efforts, there is still a lack of understanding in how to integrate IPC and research with psychologists' inclusion (Goodwin et al., 2016). Although more research, advocacy, and inclusion of psychologists in IPC have grown since Goodwin et al. (2016), current studies still encourage more psychologists to join in IPC practices. Researchers and policymakers should look at the socioeconomic factors that can affect clients' access to care as areas for future research (Lau et al., 2024).

A common theme within the current scope of research is the need for research on interprofessional collaborative practices in private practices. Research that has been done showed that interprofessional collaboration can still create benefits for practitioners and clients within non-co-located practices. Interprofessional collaboration allows for more innovative practices, which is important for future research, as this can help create new and inclusive research findings (Kwan & Hung, 2025). When collaborative interventions are created for the use of research studies, this may not be a sustainable area due to unsustainable funding (Craven & Bland, 2006).

Another area to explore is psychology's presence in interprofessional collaboration more broadly. Research on interprofessional collaboration is mainly conducted with social workers and nurses. Interprofessional collaborative practice has only been an idea that has been implemented within the past couple of decades, with psychologists only being added to these practices in 2013 (Goodwin et al., 2016). Even within CAP guidelines, the addition of interprofessional collaboration as a standard of practice was only added in 2017. Therefore, funding for research on IPC has also been limited due to many psychologists not knowing how to properly engage in

interprofessional collaborative practice (Chenneville et al., 2024). Yet the research that has been conducted shows that overall interprofessional collaboration is beneficial to professionals and clients.

To make arguments that apply to Canadian psychologists for interprofessional collaboration, future research on interprofessional collaboration, and interprofessional collaboration education, more Canadian research is needed on these topics. While there are similarities between APA and CAP standards of practices and ethics codes, there are also differences in these codes that aren't as generally applicable to Canadians, especially when looking at health care systems (Henderson et.al., 2023).

It is also important to note that many of the research studies conducted within the literature used samples with the majority of participants being Caucasian. This is often a critique of research practices, as many do not include a diverse population sample (Kwan & Hung, 2025). While this could be due to a larger systemic issue of a lack of diversity among professions such as psychologists, it is still a duty of researchers to create diverse samples (Tartas & Muller Mirza, 2007). Diverse research groups allow research to be more applicable to a wider population.

### **Summary of Next Steps for Research**

For next steps in research for interprofessional collaboration practices (IPCP), having more Canadian research studies that offer diverse sampling can allow for inclusive, applicable studies that are more relevant to the populations Canadian psychologists work with. Future research should also explore IPC within private practices to benefit both professionals and clients' accessibility to care. Lastly, psychologists specifically are found in a limited number of IPCP research studies, but their inclusion in these spaces has increased; therefore, more research

looking at the effects of IPCP for psychologists can help increase psychologists' understanding of these practices as they relate to their involvement (Kwan & Hung, 2025).

### **Ethics**

Ethical concerns in IPC revolve around professional boundaries and differences in ethical standards (Chenneville et al., 2024). Cox (2019) claimed that there are ethical similarities among disciplines, such as the ethical duty to avoid or minimize harm to the client (Henderson et.al., 2023). To limit ethical concerns, it's important that psychologists understand other collaborative professionals' ethical codes, provincial regulations, prepare for possible interprofessional conflicts, continue ethical education, and use ethical decision-making to resolve ethical conflicts.

### **Rural Communities**

According to ethical standards in the Canadian Psychological Association (2017), therapists within small communities may face more ethical dilemmas when working within small communities due to the higher rate of dual relationships within the community. This could be a deterrent for some when reaching out for therapy; therefore, having access to other mental health practitioners virtually could help with clients' feelings of privacy. When professionals live and practice within small communities, there can be a need to balance multiple roles, such as therapeutic care and assessments; therefore, additional protocols or referrals for transfers to other services will be needed (Goodwin et al., 2016). Referrals and telehealth services also become a large part of rural practices to minimize harm and ensure access to quality care, especially when seeking assessments (Kinouani et al., 2024).

## **Limitation of Scope**

In looking at the limitations of IPC practices, there are common ethics and morals for professionals, which are empathy, client alliance, cultural adaptation, and trust within collaboration (Johnson et al., 2021). While collaborative efforts are beneficial, it is also important that psychologists know the scope of limitations, as this is a core ethical concern. This scope of limitations shows the importance of self-reflection, counsellor self-care, and cultural competency. Counsellor self-reflection allowed them to gauge an understanding of limitations, collaborative relationships, and professional needs. Counsellor self-care was noted as being beneficial to long-term job satisfaction. Still, counsellors also found they had more time for self-care practices when working with IPC teams, as client concerns could be carried by multiple practitioners. Lastly, cultural competence not only helped deepen counsellor self-reflection but also created an increased knowledge base that was beneficial to therapeutic alliances with clients.

## **Shared Language**

Part of limiting ethical dilemmas is creating a shared language for practitioners to use to create a collective understanding and reduce communication errors (Stühlinger et. al, 2019). Development of a shared language can be developed in interprofessional collaboration education programs or by introducing professional terminology classification guides to help other professionals interpret language not commonly used within their profession. Shared language allows for more efficient collaboration efforts, as well as makes sharing client information easier and reduces misinterpretation. Stühlinger et. al (2019) found a positive relationship between interprofessional shared language and benefits to practitioners' relational coordination, quality of care, psychological safety, and satisfaction with their work. While this study supports the

positive results of a shared language, there are still limited studies on the benefits of shared interprofessional language.

## **Supervision**

While supervision is a requirement at all levels of psychology, interprofessional consultation and collaboration isn't, though; it could become a requirement due to the shifting needs of health care. Due to this shift in our health care systems, it is important that supervisors are knowledgeable about collaborative care (Kemer et al., 2019; Johnson et al., 2021). Supervisors offer guidance and model appropriate practices for the psychologists they supervise. Therefore, supervisors can be used as a tool for education and advocacy for interprofessional collaboration.

When looking at IPC competency, psychologists should be concerned with creating effective communication, person-centred care, effective teamwork, collaboration with goals, clarity of roles, and effective conflict resolution with collaborating practitioners (Lindblad, 2021). Supervisors are also part of ensuring collaboration efforts are successful, as supervision can be part of both individual practice and IPC teams. It is easier for IPC team supervision to be used when teams work for the same agency, as supervisors will have a better understanding of regulations and laws that affect all members of the team, as well as each discipline. This is one of the reasons why co-location collaboration is seen as more frequent in collaborative practice due to its convenience in information sharing and ability for interprofessional group supervision. IPC team supervisors should also undergo additional training in managing interprofessional teams to ensure quality of care and diverse professional ethics.

Supervisors are also useful to step in when IPC teams face conflict, as supervisors may be able to offer solutions that fit the combined goal of effective client care. Supervisors' decision-making during conflict or when faced with new ideas for client treatment can use Brodhead's (2015) Checklist for Analyzing Proposed Treatment. This checklist allows for specific factors of treatment to be examined to ensure their appropriateness for a client. While supervision can help professionals maintain ethical boundaries, each member of the team should know and maintain their profession's ethical standards. Brodhead et al. (2018) also created a self-evaluation Competence and Confidence Checklist, which is recommended to be used by professionals to evaluate their feelings of competency when working on areas outside their usual scope. This self-evaluation is useful in collaborative practices, as psychologists can have their scopes broadened due to IPC. Future research should look at improving psychologists' supervision by including IPC practices in supervision (Johnson et al., 2021).

### **Informed Consent and Electronic Health Records**

Since psychologists and many other healthcare practitioners, such as physicians, aren't permitted to discuss client cases without informed consent of collaborative practice (Knowles, 2009, & Van Liew, 2012). Even when a client gives consent to have their case collaborated on, it is still essential that all practitioners involved provide only relevant information about the client and their concerns to minimize breaches in confidentiality, especially if not all parties involved are seeing this client. This consent also needs to be extended when practitioners use Electronic Health Records (EHR). EHR's allow practitioners to easily add documentation and gain access to client records (Lois et al., 2017). This method allows for easier collaboration between practitioners and less time delays for practitioners and clients to receive changes in their records. While this efficiency is beneficial, having EHR's opens concerns of privacy and cybersecurity.

While EHR's use encrypted services that can only be accessed by professionals on secure networks to limit security risks, there are still risks of data breaches. EHR's can also affect privacy in terms of what is seen in the client's records by other practitioners (Van Liew, 2012). This is why the importance of informed consent when using EHR's is clear, both for the uses of EHR's and who will have access to them. Access can be made limited to EHR's in attempts to reduce risks of privacy breaches, although this could still be improved. EHR's also tie into the need for a shared professional language, as this shared language would help files not be misinterpreted, use only relevant client information, and create more uniform documentation (Stühlinger et al., 2019).

### **Summary of Ethics**

Psychologists working within IPC practices in an ethical way should have, the creation of a shared language, consent forms, electronic health records (EHRs), collaboration supervision, and an understanding of psychologists' limitations of practice. A shared language reduces miscommunication, while shared consent forms and EHRs allow easy communication of clients' records between collaborative partners. Collaborative supervisors also allow for shared communication and ethical guidance on interprofessional collaborative practices. Lastly, psychologists who know the limitations of their own practice allow for less overlap of care and less ethical risk.

### **Cultural Factors**

When looking at cultural integration, a challenge arises that the integrating cultures have many differences (Kwan & Hung, 2025). This is why some professional cultures are easier to integrate with, such as psychologists and social workers or physicians, as these professions fall

under similar ethical codes and responsibilities to their clients (Johnson et al., 2021). When cultures of a profession differ drastically, this can lead to more disciplinary centrism (Kwan & Hung, 2025). To combat this, interprofessional collaborative education programs (IPEC) work on creating a shared language amongst collaborators to bridge professional cultural gaps (Stühlinger et al., 2019). Part of working within a cultural context is to learn and engage in other cultural practices, which is also used with IPEC (Arredondo, 2020, & Mitchell et al., 2010). This shows the value of incorporating other disciplines' ideas to create a collaborative culture (Kwan & Hung, 2025). Psychologists being incorporated in IPC teams helps to incorporate ethno-cultural and socioeconomic factors into clients' overall wellbeing (Lau et al., 2024). These factors show how clients' interactions with systems, life conditions, social learning, and cultural experiences affect clients' interactions with health care systems.

### **Person Centred Care**

In the person-centred care model, psychologists work to understand client concerns, provide trauma-informed care, and create a positive alliance (Mahoney et al., 2017). This approach helps to mitigate health trauma. This approach is beneficial to people within minority groups of race or sexuality, as these demographics have often experienced the most healthcare-related traumas (Pace et al., 2021). IPC in person-centred care with minority groups can also offer a sense of overall care and safety felt by clients, as these clients will have a network of supportive health care providers, which could help mitigate previous health trauma (Mahoney et al., 2017). Additional training and continued competencies when working with minority groups are encouraged due to the levels of harm this population faces and the risks of harmful care (Pace et al., 2021, & Mahoney et al., 2017). This is further supported by practitioners supporting clients' autonomy and ability to describe their narratives.

### **First Nation Collaboration**

Minore and Boone (2002) found that IPC teams reflect collaborative work within First Nations communities, as members of the community work together with professionals but also seek knowledge from elders. Collaborative practices can help professionals diminish cultural barriers by using the client-centred approach of gaining knowledge from their clients and their culture while incorporating IPC knowledge. Considering the need for services in Northern Canada and other communities, many professionals who work in these communities already work to collaborate with other professionals outside of the community, but this is only effective if professionals outside the community are open to collaborative practices.

### **Summary of Cultural Factors**

Since culture is an important aspect of creating effective care for clients, it is important that psychologists remain educated on incorporating culture into care practices (Arredondo, 2020, & Mitchell et al., 2010). Future clinical work and research should look at incorporating community supports that relate to clients' cultural needs, as well as allow psychologists to become more knowledgeable about the communities they serve. This is especially important within rural and northern areas of Canada the needs of these communities are complex. Communities with large First Nations communities can benefit from psychologists' incorporation into interprofessional collaborative care due as these communities often operate within collective teaching and support (Minore and Boone, 2002).

### **Reflexive Conclusion**

Throughout this paper, I ensured that I included points from the literature that included both negative and positive support for my paper. This was demonstrated through my highlighting

of the benefits and downsides of interprofessional collaborative care. I also did a lot of self-reflection notes throughout this paper on how certain findings from the literature or conversations from my practicum made me feel. I found it validating when discussing interprofessional collaboration with others at my practicum who had worked within this context, as they also highlighted its importance. While all mentioned its importance, there was also a discussion of its challenges.

As I reached the end of my practicum, I also became aware of how many hoops need to be jumped through before information can be shared. While this is for the protection of client and program information, it does create barriers to working collaboratively. I also found that by the end of my practicum, I began to lose faith in a lot of systems as I witnessed how clients had been negatively impacted due to others' ethics or systematic barriers. This challenge to my original belief created additional reflection on the challenges of collaboration. Working on this paper, finding evidence supporting IPC within the literature, and witnessing clients at my practicum improve through IPC, created the reignition of passion for this topic. Experiencing some of my own pros and cons of IPC allowed me to better reflect on IPC's importance. Witnessing clients who benefited from having multiple supports and the benefit of my collaboration and advocacy with these supports to help the client have a better experience in care. This benefit was measured at my practicum using the Outcome Questionnaire-45 (OQ), which is a tool used for measuring client outcomes based on self-reports of mental health-related questions (Lambert, 2015). OQs that I witnessed showed improved scores after interprofessional collaborative practices were invoked, especially that of psychiatrist and counsellor collaboration.

When reflecting on the saturation of my literature review, I found it helpful to look at references cited in the journals I used to either collect more resources or to verify the use of the

resources I chose. Many journals I searched the references for had similar repeated articles that I used within my literature review. Some articles allowed me to find other resources that didn't pop up within my school's research library. A lot of articles used other resources that didn't fit my literature review's aim but were useful to show that research articles done of interprofessional collaboration do need research support from other areas, due to there still being limited research.

### **Summary of Reflexive Conclusion**

My own complex experiences and research on the effects of interprofessional collaborative practice (IPC) for patients' overall mental health have led me to a deeper understanding of the challenges and benefits of IPC. Firstly, from my research, IPC is not taught enough in all forms of care studies, especially at levels lower than PhD (Patterson et al., 2021). Secondly, the need for research on IPC with the inclusion of psychologists in both private and collaborative settings needs to be expanded. Finally, there needs to be an improvement in professional perspectives of IPC, as my research has shown support for my research question that IPC practices improve clients' overall mental health benefits.

### **Conclusion**

This paper illuminates that interprofessional collaborative practice (IPCP) can help make a measurable improvement in clients' overall mental health. This is achieved by supporting clients navigating challenging systems, lessening treatment wait times and allowing collaboration between clients and practitioners. Benefits not only extend to clients but also to practitioners as well, with additional referrals, more understanding of clients, allowing for better choices in treatment plans, and lower costs in marketing or building fees (if co-located). As the health system shifts from individualized practices to collaborative ones, psychologists should prepare to incorporate more IPCP (Mellin et al., 2011). When looking at the importance of

interprofessional collaboration (IPC) for psychologists, IPC helps psychologists with the continuation of competency, inclusivity, diversity, and effective care for complex cases; these are elements that are beneficial to practitioners and their clients (Johnson et al., 2021). Future research on IPCP should include more inclusive Canadian studies that focus on psychologists' involvement in IPCP.

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### Appendix: Methodology Chart

<u>Authors Year</u>	<u>Title</u>	<u>Sample Size</u>	<u>Selection/ Recruitment</u>	<u>Data Collection Process</u>	<u>Data Analysis Process</u>	<u>Qual/Quant /Mixed/Cas e</u>	<u>Notes on finding</u>
Goodwin, S., MacNaughton-Doucet, L., & Allan, J. (2016).	Call to action: Interprofessional mental health collaborative practice in rural and northern Canada.	Literature Review	Literature selection based on peer-reviewed journals that look at interprofessional mental health collaborative practice (IMHCP) as a response to the need for rural mental health care in Canada	Data was collected through a literature review of numerous sources for IMHCP need, training, and utilization in rural communities in Canada.	Systematic literature review	Qualitative Literature Review	The review is a call to action for psychologists' collaboration in IMHCP to combat growing mental health concerns in rural Canada. This review highlights the need for interprofessional collaboration education programs to help those based in these rural regions connect with professionals outside of rural places. This review also highlighted the need for psychologists in interprofessional collaboration and the need for system change to support rural populations.
Brodhead, M. T., Quigley, S. P., & Wilczynski, S. M. (2018).	A call for discussion about the scope of competence in behaviour analysis.	Literature Review	Literature selection based on peer-reviewed journals that look at defining scope competence, negatives working outside of scope/ways to improve scope competence, a multidimensional model of scope competence and self-evaluation.	Data was collected through a literature review of numerous sources based on the literature selection to discuss the scope of competence and areas that affect competence in behavioural analysis.	Systematic literature review	Qualitative Literature Review	The multidimensional model of competence and the Competence and Confidence Checklist (CCC) help professionals understand and evaluate their scope of practice. These serve as a baseline for evaluating competence, although ethical and professional behaviours will also need additional monitors. This study begins a discussion on practitioners' competence and understanding limits of professional scope.
Woo, H., Lu, J., & Bang, N. (2018).	Professional Identity Scale in Counselling (PISC): Revision of factor structure and psychometrics.	385 counselling professionals, 287 men, 96 females, and 2 who did not disclose gender.  The second sample consisted of 286 counselling professionals, 222 female and 64 males.	Participants were used in the original PISC data collection and were all in counselling or counselling-related roles. Ages ranged from 21-72, and most participants identified as white (79.48%).  Second sample participants also ranged in age between 21-72,	An exploratory factor analysis of the archived data from Woo & Henfield's (2015) data collection. Used principle factor analysis to reexamine the original PISC factors.  The second study conducted was the main research study,	Exploratory factor analysis and confirmatory factor analysis	Quantitative study	This study was designed to create a viable shortened version of the PISC. This shortened version contained 16 items and four factors (professional knowledge, attitude towards profession, engagement in profession, and professional competency). The findings allow a viable test for professionals to evaluate aspects of professional identity and longevity in counselling careers. Using this form of testing serves an important role in developing professional

			and most participants identified as white (80.07%).	which used confirmatory factor analysis to determine if the shortened version of PISC was viable.			identity and identifying points that maintain career longevity.
Greidanus, E., Warren, C., Harris, G. E., & Umetsubo, Y. (2020).	Collaborative practice in counselling: a scoping review.	Literature Review	Literature was selected from 40 articles published in 2012-2015. Limited to peer-reviewed papers written in English that focused on counselling, with further inclusion of collaborative practices.	Data was collected through a literature review of numerous sources for	Scoping Literature Review	Mixed Methods Literature Review	A scoping literature review looking to answer the question of what a counsellor's role in collaborative care entails. This review highlights types of collaboration, treatment coordination, future implications for collaborative practice for counsellors, and the benefits/challenges of collaborative practice. Findings found that while many of the provinces' counselling standards included mentions of collaborative practice, only a small number mentioned interprofessional collaboration. Recommendations of this study suggest adapting consistent terminology among provincial codes and increasing advocacy for collaboration with mental health professionals.
Kwan, L. Y., & Hung, Y. S. (2025).	Unveiling the influence of disciplinary biases on information sampling during an interdisciplinary collaboration creative task through eye-tracking analysis.	93 undergraduates, 50 men and 43 women.	Participants came from engineering and business programs (the University was not specified). Students were all in their third or fourth year of training. The average age was 21.27. 80% had one year of work experience.	Data was collected by evaluating trait values within market orientation and problem-solving orientation. A higher score on the Professional Orientation Scale indicated bigger perceived differences among professions. Intellectual centism was measured with a creativity	Mixed Methods Analysis of variance from within-subject factors based on responses to professional trait value	Mixed Methods Analysis	This study found that individuals who stayed within their own professional groups saw more differences between other disciplines and trait values. This higher focus on one's own discipline showed an increase in perceived difference during the creativity task. This study empirically proved previous studies' findings that individual profession centism had damaging effects on intellectual tasks.

				task that required designing or redesigning.			
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