Who Helps the Helpers? A thematic enquiry into the organizational correlates of burnout through the lens of clinical psychologists in Quebec's mental health teams

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Abstract

Who Helps the Helpers? A thematic enquiry into the organizational correlates of burnout through the lens of clinical psychologists in Quebec's mental health teams

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Background: It is generally accepted that mental health professionals experience high levels of burnout. Burnout is a multi-dimensional phenomenon that occurs because of a complex interplay between individual and contextual factors.

To understand the impact of contextual factors on burnout among mental health professionals, I looked at how recent healthcare reforms have altered the mental health service delivery and then examined the impact of resulting changes to the work environment on burnout. Specifically, I focused on the creation of primary mental health teams and the experiences of clinical psychologists working in them.

Objective: To identify the organizational correlates of burnout associated with interdisciplinary teamwork in primary care.

Method: Eight semi-structured interviews were conducted targeting full-time clinical psychologists in primary care. Participants reported the job demands associated with teamwork and the resources available to meet those demands. The interviews were conducted in person and over the telephone in both official languages. The audio recordings of the interviews were transcribed and analyzed using thematic analysis.

Results: The participants reported six job demands that clustered around three areas of work-life: control, workload, and community. Five resources were classified as functional, motivational, and professional development. The former contributed to their stress experience, whereas the latter were instrumental in achieving work goals, and satisfied basic human needs for relatedness and competence.

Recommendations: Improve participative decision-making and autonomy; adequate provisions for consultations; reduce administrative burden; develop a digital integration strategy and protocols for knowledge creation.

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To my family and friends, thank you for your emotional support and reassurances throughout this journey. Mr. Benoit Brassard, thank you sharing this journey with me and gifting me your time. And lastly, I extend my sincerest thanks to all the hardworking psychologists who participated in the study. Your commitment and candour made this project possible.

Dedication

This thesis work is dedicated to my parents, Parveen and Ali Aziz, who have always loved me unconditionally and whose good examples have taught me to work hard for the things that I aspire to achieve.

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Introduction

Mental health professionals (MHPs) working in public healthcare system encounter a high degree of complexity on a daily basis. There are many aspects of work that contribute to this complexity, including the emotional demands of providing mental healthcare, the nature of the job, and features of the organization (Green, Albanese, Shapiro, & Aarons, 2014). Consequently, it is now well established that MHPs experience high levels of job burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012).

However, in recent decades, healthcare reforms have added a new dimension to the complexity encountered by MHPs at work. Not least because reforms result in sweeping organizational changes that alter the work environment, but they also contribute to the stress and uncertainty experienced by health professionals (Van Eyk, Baum, Hauton, 2001). Research reviewed in this report demonstrates that chronic, work-related stress leads to poor health outcomes among MHPs, problems of attrition, and subpar mental health service delivery (Morse et al., 2012). The social cost of burnout is a cause for concern, underscoring the need to better understand the work environment (i.e. job and organizational characteristics) in which MHPs work.

This study looks at three healthcare reforms in Quebec (Bill-25, 2005 Mental Healthcare Reform, and Bill-10) and focuses on the experiences of CPs working in interdisciplinary teams in primary care, with the objective to identify the organizational correlates of burnout and contribute to the literature on job stress and burnout by expanding our knowledge about the nature of negatively-valued job characteristics that contribute to the stress experience of CPs, ultimately leading to burnout; and the role of positively-valued job characteristics in reducing this stress.

Burnout

What is burnout?

Maslach, Schaufeli, and Leiter (2001) describe burnout as a 'psychological' response to chronic work-related stress marked by three distinct features: exhaustion, feelings of depersonalization (or cynicism), and a diminished sense of personal accomplishment (or inefficacy). Exhaustion captures the stress component of burnout and manifests as feelings of being drained of one's physical and emotional resources. Depersonalization captures the interpersonal component of burnout and shows up as a detached attitude towards patients, colleagues, or work in general. Finally, reduced feelings of personal accomplishment capture the self-evaluation component of burnout and refers to feelings of incompetence and lack of achievement at work (Maslach et al., 2001).

The authors also point out that burnout is a process that unfolds over time, during which the three dimensions reinforce each other in a feedback loop (Maslach et al., 2001). For example, the energy required to deal with the work overload leads to exhaustion. Over time, the exhaustion triggers a defense mechanism, and people respond to it by emotionally distancing themselves from their work as a self-protective strategy to prevent more energy from depleting. The developing feelings of cynicism contribute to a diminished sense of efficacy, which in turn adds to the feelings of exhaustion. Research has also shown that unlike the link between exhaustion and cynicism, the relationship between cynicism and inefficacy

is not necessarily sequential (Leiter, 1993). In fact, feelings of inefficacy develop in parallel with exhaustion and cynicism. Moreover, the relationship between inefficacy and the other two aspects of burnout is also not as straightforward. For example, depending on the context, inefficacy can result from either exhaustion, cynicism, or a combination of the two (Lee & Ashforth, 1996).

Burnout vs. Common Mental Disorders

Broader discussions among clinicians, researchers, and insurance providers on whether burnout is a mental disorder warrant a brief discussion to support my decision to examine burnout instead of common mental disorders as an outcome to investigate work-related stress. Common mental disorders like major depression and anxiety are officially recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013). Consequently, they are treated as diseases rooted in the bio-psycho-social model. Employing common mental disorders to evaluate work-related stress has an apparent advantage, i.e. clinical diagnostic legitimacy conferred by the DSM.

However, from an organizational research perspective, we argue that burnout is better than common mental disorders for evaluating work-related stress. The bio-psycho-social conceptualization of common mental disorders means that work-related stressors cannot be isolated from stress in personal life (van Dam, 2021). The reason is that, from a biological point of view, the source of stress is irrelevant, i.e. it doesn't matter whether the stressors come from work life, personal life, or both. What matters is how stress impacts 'biological functioning in the organism' because that affects the 'psychological processes and social behaviour' (van Dam, 2021; p. 732). In this way, common mental disorders are related to stress in general.

In contrast, burnout is a multidimensional construct that focuses exclusively on work-related stress. Accordingly, organizational researchers can use it to investigate the work environment and identify factors contributing to employees' stress experience. On a more practical level, burnout as a construct excludes stress emanating from personal circumstances about which the organizations may feel less responsible and can therefore be engaged in discussions on their role to provide a healthy work environment.

Predictors of Burnout

Burnout is a confluence of individual, occupational, job, and organizational characteristics (Maslach, Schaufeli, Leiter, 2001). At the individual level, personality characteristics such as low levels of hardiness, external locus of control, as well as passive and defensive coping styles are more likely to experience burnout (Maslach, Schaufeli, & Leiter, 2001).

Among the demographic variables: age and gender have been linked to burnout (Maslach, Schaufeli, & Leiter, 2001). A meta-analysis examining the relationship between age (or years of experience) and employee burnout found a slight negative correlation between employee age and emotional exhaustion (Brewer & Shapard, 2004). However, as per Maslach and colleagues (2001), this finding should be interpreted with caution given the possibility of survival bias (individuals with lower levels of burnout may be overrepresented because they survived and stayed at their jobs, compared to those that burned out and quit early in their careers). Another meta-analysis on gender differences in burnout conducted by

Purvano and Muros (2010) found that women reported higher levels of emotional exhaustion while men reported higher levels of depersonalization.

The two variables of interest among job characteristics, including workload and inadequate social support, have been linked to burnout. The workload is the most basic aspect of any job. People experience work overload when they have "too much to do in too little time with too few resources" (Leiter & Maslach, 2004; p. 95). Burnout research has shown a consistent and positive relationship between increasing workload and exhaustion, which mediates the relationship of workload with the other two dimensions of burnout (Maslach, Schaufeli, & Leiter, 2001; Lee & Ashforth, 1996; Leiter & Harvie, 1998). However, research in the mental healthcare field has produced mixed findings (Green, Albanese, Shapiro and Aarons, 2014). For example, caseload size in clinical mental health is analogous to workload and is often used as an objective measure of burnout (Green et al., 2014). Acker and Lawrence (2009) found that larger caseload size was related to role stress, but not emotional exhaustion among MHPs in managed care. On the other hand, Garner, Knight, and Simpson (2007) found no significant relationship between caseload size and burnout among social workers. Indeed, Green and colleagues (2014) did not find significant effects between caseload size and burnout as well. These findings demonstrate that treating caseload size as the totality of MHPs workload may not be capturing the full-picture. There may be other non-therapy-related job tasks that be may be contributing to exhaustion. Inadequate HR is another aspect of job characteristics that contributes to work overload. de Paiva Fonseca and Mello (2016) surveyed nursing professionals and found that lack of HR contributed to an increase in their relative workload that resulted in stress and represented a health risk. Social support is another aspect of job characteristics. This construct captures employees' perceptions or experiences that they are cared for, valued, or part of a social network of mutual assistance (Taylor, 2011). It satisfies the basic human need of relatedness, and there is an extensive body of research demonstrating that lack of social support is linked to burnout (Schaufeli & Taris, 2014; Leiter & Maslach, 2004).

The organizational climate has emerged as a relevant variable among researchers looking to unpack the impact of organizational characteristics on burnout (Green et al., 2014). Simply put, organizational climate captures employees' experience and the shared meaning they attach to the organization's policies and practices (Schneider, Ehrhart, & Macey, 2013). This construct has many conceptualizations. But Green and colleagues (2014) operationalized it as role conflict and role overload in survey research completed by 285 mental health service providers across 49 mental health programs. Interestingly, they found organizational climate variables accounted for the greatest variance in provider-reported burnout.

Clinical Psychologists and Burnout

CPs encounter many stressful demands unique to mental healthcare, making them especially vulnerable to burnout. Starting with the role of a CP, which is to examine, understand, and improve the life of a human being (Skovholt, 2003). This job is challenging in and of itself because people are complex, and personal change is a slow process. Plus, mental health work calls for intense emotional engagement with patients over an extended period. Clinicians engage in 'empathic attachment', 'active involvement', and 'felt separation' multiple times a day (p. 49, Skovholt, 2003). This advanced skill set requires them to

constantly regulate their emotions when relating to patients, leading to emotional exhaustion.

In addition to emotional demands, mental health work is inherently ambiguous, placing significant cognitive demands on CPs. Take the task of diagnosing the problem. Research has shown that patients' self-evaluation of their illness is often unclear (Han, Klein, Arora, 2011). According to Skovholt (2003), CPs make clinical decisions based on incomplete, vague, and ambiguous information. In addition, the author notes there is a lack of professional consensus on effective strategies for helping patients, which is another factor that contributes to a sense of uncertainty around professional tasks, especially among novice clinicians. Adding to the mix of stressors, CPs working in primary care in the public system provide sophisticated care to patients with chronic medical conditions in a fast-paced environment over a short period (Whitebird et al., 2017).

Other stressful aspects of mental healthcare work include patient-demands, such as: negative behaviour (violence and harassment), treating involuntary-detained patients against their will, and caring for patients at risk for committing suicide (Johnson, Hall, Berzins, Baker, Melling, Thompson, 2018). On the issue of violence, Ackerley, Burnell, Holder and Kurdek (1988) found a positive correlation between negative patient behaviour and all three dimensions of burnout. Regarding involuntary detention, Thornton (1992) noted that MHPs working in publicly funded inpatient clinics reported higher rates of burnout than those working in outpatient clinics. Finally, on the risk of suicide, Hagen, Knizek and Hjelmeland (2017) explain that caring for patients at risk for suicide is emotionally taxing because it requires constant monitoring and management of the potential risk of suicide. Taken together, it is not surprising then that 21 - 67% of mental health professionals experience high levels of burnout (Morse et al., 2012). A review conducted by Morse, Salyers, Rollins, Monroe-DeVita, and Pfahler (2012) cited three American studies in which 36% to 54% of mental health professionals reported high levels of emotional exhaustion. Similarly, Oddie and Ousley (2007) conducted a review of UK-based studies and found that 21%-48% of general mental healthcare workers reported high levels of emotional exhaustion.

Social Cost of Burnout

Burnout starts with an individual, but it has a far-reaching cascade of adverse effects. A person suffering from burnout is more likely to experience poor health outcomes such as depression, sleep problems, flu-like symptoms, back pain, and increased substance use (Morse et al., 2012). The negative attitude of workers with high levels of burnout has an impact on the morale of other employees and may lead to turnover (Stalker & Harvey, 2002). Burned-out care providers are also less likely to be empathetic and attentive, and that influences their interactions with high-needs patients who report lower satisfaction with services (Garman, Corrigan, & Morris, 2002). Furthermore, Burnout is also correlated with absenteeism; the 2016 figures suggest that mental health care staff take more sick days than those in acute and primary care (Johnson, Hall, Berzins, Baker, Melling, & Thompson, 2018). Turnover and absenteeism in turn impact the quality of service and continuity of mental healthcare (Carney, Donovan, Yurdin, & Starr, 1993; Boyer & Bond, 1999).

Job Demands-Resources Model

To identify the work-related stress factors contributing to the burnout experience among CPs, I employed Schaufeli & Bakker's (2004) revised Job Demand-Resource (JD-R) model. It is one of the leading job-stress frameworks that assesses the impact of job characteristics on employee's health and well-being The JD-R evaluates the impact of job characteristics on employee health and wellbeing by focusing on two aspects of working conditions: job-demands and job resources (Schaufeli & Taris, 2014). Job demands are negatively valued job characteristics that require sustained effort; these aspects can be physical (manual tasks necessary to do the job), psychological (cognitive & emotional), social (interpersonal), or organizational (physical working conditions). In contrast, job resources are positively valued job characteristics that may do any of the following: be functional in achieving work goals, satisfy the human need for connection, stimulate learning and development (Schaufeli & Taris, 2014).

The framework posits that an employee's health and wellbeing is contingent on the balance between positive and negative aspects of the job (Demerouti et al., 2001). In other words, job demands and resources in the work environment impact employees' wellbeing. As shown in Figure 1 (reproduced from Shaufeli & Taris, 2014), when job demands are high, workers must put in the additional effort to achieve work goals; if they do not get an adequate opportunity to recover, it can lead to burnout. Similarly, when job resources are low, workers are required to put in more effort to achieve work goals, which can also lead to burnout. Over time burnout can lead to negative outcomes (such as health problems; poor organizational functioning). On the other hand, when job resources are high, they can play a motivational role and contribute to an employee's wellbeing through the achievement of work goals or satisfaction of basic needs of competency, relatedness and autonomy. Well-being, in turn, can lead to other positive outcomes such as high organizational functioning.

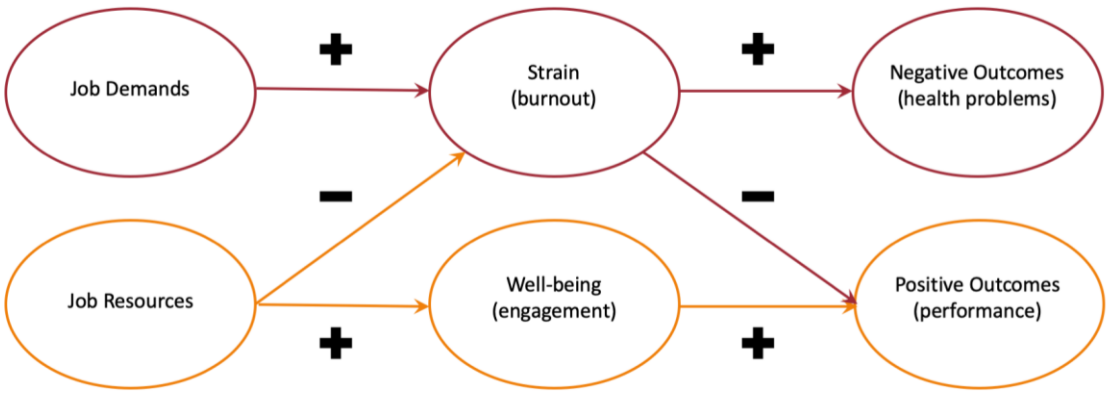


Figure 1: The Revised Job Demands-Resources Model (Schaufeli & Taris, 2014)

Québec's Healthcare System

In this thesis, I look at how recent healthcare reforms in Quebec have altered the mental health service delivery in primary care and examine the impact of resulting changes to the job characteristics on burnout. Specifically, I focus on one organizational change (creation of interdisciplinary mental health teams in primary care) linked to the 2005 mental health service delivery reform (henceforth, MHR). However, the 2005 MHR was implemented amid two Health system reforms, namely Bill-25 (Government of Québec, 2003) and Bill-10 (Government of Québec, 2015), that overhauled the province's entire healthcare system. Given the scope of these reforms, this section begins with a brief description of how Quebec's Ministry of health and social services (MSSS) has organized the health services to provide the context in which the MSSS implemented these reforms.

The organization of health and social service

There are 18 health regions in Quebec. Each region is further sub-divided into territories and local service networks. Altogether there are 22 territories and 93 local service networks in the province of Quebec (MSSS, 2015). For example, among the 18 health regions (Figure 2), Montreal is designated Health Region No. 6 (Figure 3). It consists of five territories with up to 3 local service networks within each territory (MSSS, 2015).

The MSSS has organized health and social services within each territory around nine service programs and three support programs (MSSS, 2015). Among the nine service programs, public health and general services respond to the general population's needs. The remaining seven service programs deal with specific issues, including mental health, youth with difficulties, intellectual impairments and autism spectrum disorder, dependencies

Figure 2: Health Regions of Quebec (MSSS, 2015)

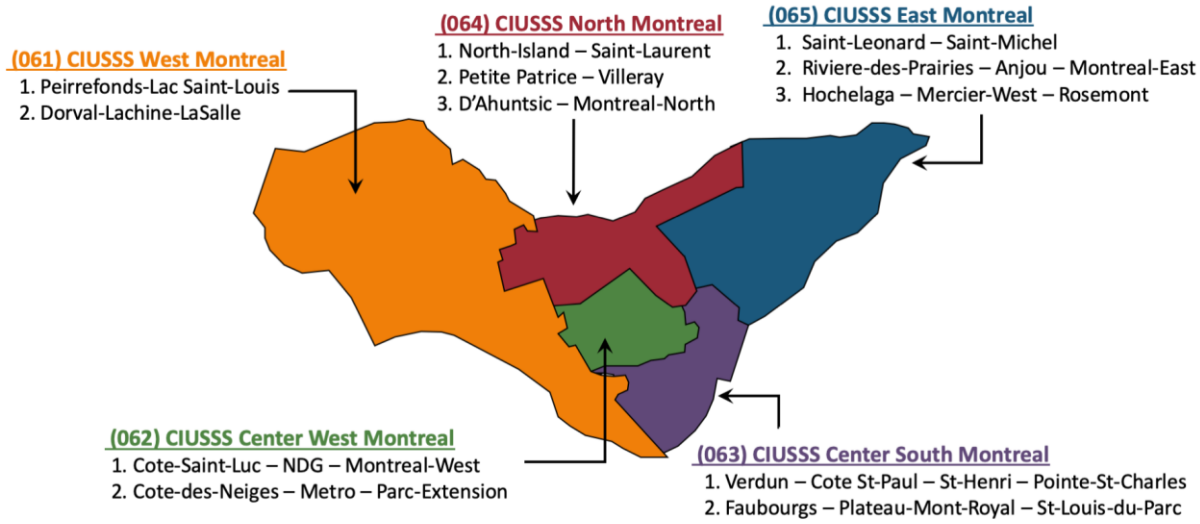


Figure 3: Montreal (Health Region #6)

(alcoholism, drug addiction, and compulsive gambling), support for independent seniors, physical disabilities (i.e., impairments related to hearing, vision, language, speech, and motor activities), and physical health, which covers emergency services, specialized and highly specialized services, continuous services requiring systematic follow-up (for example, chronic disease, cancer) as well as palliative care. The three support programs (administration, service support, and building & equipment management) provide administrative and technical assistance to service programs.

Healthcare Reforms

Historically changes to the healthcare system in Quebec have been driven by advice from public commissions. For example, recommendations from the 1985 Rochon commission led to the creation of the 18 health regions in 1991 (Martin, Pomey, & Forest, 2006).

Bill-25: More recently, the 2000 Clair commission diagnosed the healthcare system as facing significant organizational problems and warned that it would be 'dangerous' to allow these problems to exist (p. v, Maioni, 2001). Among other things, Mr. Clair pointed out: problems with access, quality, and efficiency in service delivery, the need to improve the population's health, and lack of accountability & transparency throughout the system that ultimately led to reforms legislated by Bill-25. This bill ordained the establishment of 93 local service networks and the creation of health and social service centers from the merger of community centers (CLSCs), residential and long-term care centers (CHSLD), and in many cases, hospital centers (CH) (See Figure 4). A single board of directors headed this new institution, and they were responsible for: building agreements with partner organizations, monitoring the population's health, and offering a full range of services to people within the territory at the local level (Martin et al., 2006).

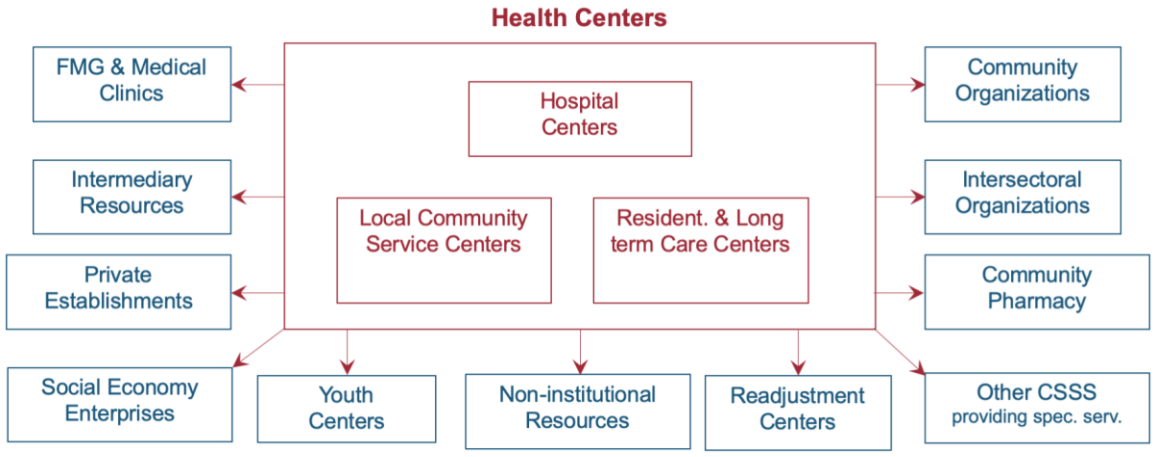


Figure 4: Health Center & Local Service Networks (LSN)

2005-2010 Mental Health Action Plan (MH-Reform): Then, two years later, in 2005, the MSSS rolled out the MH-Reform. Key issues that underscore the need for MH-Reform include insufficient services for common mental disorders (such as depression & anxiety), long wait times for psychiatric care, and an inefficient mental health service delivery with inadequate quality of care (Fleury et al., 2016). The MH-Reform, in turn, mandated a significant re-organization of the mental health services in primary care. Specifically, the MH-Reform laid out a framework to enhance mental healthcare in primary care by pursuing the triple aim of increasing access to MH services, improving quality in primary care, and increasing efficiency by improving coordination between primary care & specialized services (Fleury et al., 2016)

To improve access to services, the MH-Reform mandated the implementation of interdisciplinary teams such as MH primary care teams for treating common MH disorders such as depression and anxiety (MSSS, 2005). Moreover, the size of a territory's population determined the number of teams. The MSSS forecasted an MH primary care team of 20 full-time psychosocial clinicians and two GPs per 100,000 inhabitants (MSSS, 2005). To improve the quality of MH service delivery, the MSSS recommended two reform initiatives; first, it promoted shared-care by hiring respondent-psychiatrists to provide consultation and support to interdisciplinary teams and general practitioners. Second, the MH-Reform recommended that clinicians incorporate evidence-based clinical interventions and best practices such as cognitive behavioural therapy and standardized evaluation tools (Fleury et al., 2016).

Bill-10: Ten years later, in 2015, Bill-10 eliminated the middle-level of governance by abolishing the regional agencies (Government of Québec, 2015). Bill-10 also pursued the integration agenda by merging the Youth Protection and Rehabilitation Services with the Health Centers, resulting in a new institution called Integrated Health and Social Service Center (Quesnel-Vallée & Carter, 2018). The Integrated Centers are responsible for building agreements with other partner organizations (Figure 5). Still, the agencies' responsibilities have been reassigned in part to the Ministry and the Integrated Health Centers (MSSS, 2015).

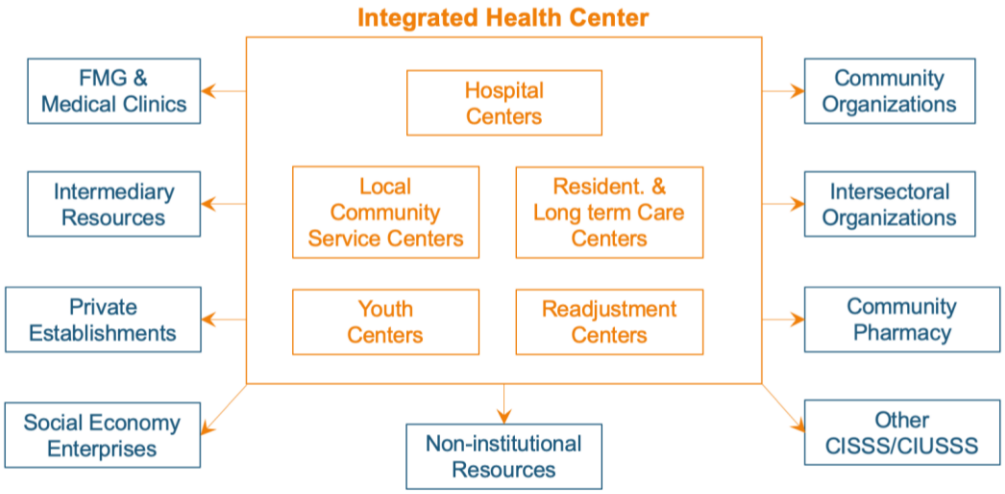


Figure 5: Integrated Health and Social Service Center

Research Questions

The reforms discussed in the previous section significantly altered the healthcare landscape in Quebec. In this thesis, I focus on one organizational change, i.e. the implementation of primary mental health team to treat common mental disorders. Research has shown that organizational changes create uncertainty, which in turn produces anxiety among employees and leads to attrition (Onyett, 2011). There is, therefore, a cause for concern because a significant number of MHPs are willing to leave their work if an opportunity presents itself, much to the detriment of the community they serve (Happell, Martin, & Pinikahana, 2003). This is especially true for CPs, given the low barriers to entering private practice. The combination of CPs' vulnerability to burnout and high attrition following organizational changes confirms the pressing need to prioritize the organizational context of teams in which CPs work.

Hence, the purpose of the study is to identify the organizational correlates of burnout among CP working full time in interdisciplinary teams in primary care. To do this, I will answer the following three research questions:

RQ1: What was the burnout experience of CPs?

RQ2: What job demands did CPs encounter while working in interdisciplinary teams in primary care?

RQ3: What job resources were available to CPs to buffer the impact of (interdisciplinary team) job-demands?

In addition to identifying the organizational predictors of burnout, the findings from this study will contribute to the literature on JD-R by expanding our knowledge about the nature of job demands experienced by CPs and the types of resources they find helpful. The results will contribute to the current knowledge on the JD-R model by validating quantitative findings from previous studies. Finally, the contextual data from the present study will also contribute to new knowledge on the JD-R framework by providing empirical support to generate hypotheses for testing and research questions for future studies.

Methodology

This chapter begins with an outline of the research objective and design. Next, I provide the rationale for my assumptions and analytical considerations, followed by an overview of the participant selection and recruitment process. After that, I describe the tools I used for collecting data and present my approach to conducting thematic analysis. Finally, I conclude this chapter with a section on preparing the dataset for analysis.

Research Objective and Design

The goal of this study was to identify the organizational correlates of burnout in primary-care from the perspective of CPs. To do this, I interviewed eight clinical psychologists working in primary care teams to answer the three research questions (RQ) above.

Assumptions and Considerations

Before I began the data analysis, I reflected on the following questions to clarify my assumptions and the process that informed my thematic analysis: what counted as a theme? What was the role of theory in identifying themes? What was my epistemological position? What framework would I employ to conduct the analysis? As per Braun and Clarke (2006), this step was necessary because, without it, it would be challenging to evaluate a qualitative study and compare it to others. The lack of clarity on the assumptions also prevents other researchers from carrying out related research projects in the future (Attride-Stirling, 2001).

Theme: According to Braun and Clarke (2006, p. 82), a 'theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set.' To determine what size a theme needed to be or counted as a theme, I considered its prevalence and evaluated the number of times it came up in the dataset. Even though it is preferable to have several instances of a theme across the dataset, more instances do not automatically imply that a theme is more important. According to Braun and Clarke (2006, p. 82), a 'theme might be given considerable space in some data items, and little or none in others, or it might appear in relatively little of the data set.'

For this reason, I maintained flexibility in my approach and used my judgement to identify a theme. Ultimately, I 'measured' a theme's prevalence at the level of the data item (i.e., did it appear anywhere in the interview) as well as the number of individual occurrences across the dataset. It does not mean that I excluded the non-prevalent themes from consideration because it is possible for a theme to be relevant without being prevalent, especially if it captured something significant about the overall research question (Braun & Clarke, 2006).

Role of Theory – Job Demands-Resources Framework: The objective of this research project was to identify the organizational correlates of burnout. To do this, I predominantly employed a deductive approach to knowledge generation and used Schaufeli and Tarris's (2014) revised Job Demand-Resource (JD-R) model to initially code the data. However, as Braun and Clarke (2019; p. 58) note, 'in reality, coding and analysis often [involves] a combination of [inductive and deductive approaches] … [one] rarely completely ignore[s] the semantic content of the data when [coding] for a particular theoretical contruct'. For this

reason, I pursued a hybrid 'V' method by merging deductive and inductive approaches. For example, after tagging the data excerpts based on the JD-R coding framework in phase-2 (deductive), I reviewed the semantic contents of each extract in phase-3 when I searched for themes (inductive). See the section on the Approach to Thematic Analysis.

Direct Realism: My aspiration for this research project was to generate knowledge that reliably captured the job characteristics of CPs working in primary mental health teams and, in doing so, identify the organizational correlates of burnout.

With this goal in mind, I considered my epistemological position for this project (i.e. realist versus relativist). A realist perspective aims to shed light on reality by taking data (i.e. participants' description of events) at face value and producing knowledge about the 'social world in terms of the events that are actually taking place'. On the other hand, a relativist position is 'not concerned with the truth value of what participants are telling'; instead, the goal is to produce knowledge about the 'social world in terms of actions that research participants are taking when they construct meaning' (Willig, 2012; p. 8-9). Given that my goal was to produce knowledge about events that took place in the world led me to choose the realist perspective and rule out relativist positions (i.e. phenomenological and social constructionist).

Next, I reflected on my approach to qualitative research, i.e. direct versus interpretive. The two approaches differ in the degree to which they 'aspire to move beyond the data' and 'interpret what is being presented' (Willig, 2012; p. 8). A direct (or descriptive) approach to qualitative research stays close to the participant's account of their experiences and aims to find meaning in the data itself (i.e. spoken word). Whereas, an interpretive approach seeks to move further from the data and give meaning to the participants' experiences that are not even obvious to them. Again, my goal was to reflect the experiences of CPs and keep my interpretation to a minimum. Accordingly, I chose the direct approach over the critical or interpretive approach.

The outcome of my reflections on epistemology and qualitative approaches led me to direct realism. Qualitative research based on direct realism is underpinned by the assumption that specific (psychological and social) processes shape research participants' thinking and behaviour in each context, and a skilled researcher can discover these (Willig, 2012). This approach to knowledge generation also assumes that a 'relatively uncomplicated and direct relationship exists between what presents itself (the data) and what is going on (the reality we want to understand)' (Willig 2012, p. 13).

Hence, I identified the themes in the data set at the semantic level, meaning I looked for themes within the data's explicit meanings. That is not to say that I limited my analytic process to merely summarizing the data and identifying the patterns in semantic content. I took it a step further and compared the experiences of CPs with varying levels of burnout (i.e. those that experienced burnout, those that experienced some symptoms of burnout, and those that did not experience burnout) and interpreted the differences in their work environments. In this regard, my role as a researcher was that of a detective, and my task was to reveal the 'hidden facts' and make 'what appear[ed] puzzling intelligible' (Willig 2012, p. 11).

Finally, to reflect the participants' realities as honestly as possible, the readers needed to get a complete picture of all the relevant themes. Therefore, I made sure that the themes that I coded, analyzed, and presented in the final analysis accurately reflected the contents of the entire data set. In doing so, I recognize that I lost some depth but captured a detailed overall description. Braun and Clarke (2006) confirm that this is an appropriate approach when a research study involves a group whose perspectives on a topic are not known.

Before concluding the discussion on direct realism, it should be noted that even though this approach is appropriate for reporting the participants' experiences and matches with what I wanted to know, it is not without shortcomings. The limitations include, the exclusion of interpretation of non-verbal cues, overlooking participants' self-interests, and poor memory recall.

Participant Selection and Recruitment

This study is part of a larger research project that targeted CPs working in Quebec's public healthcare system regardless of their employment status or the team setting. In other words, the participants could be full-time or part-time employees in primary care, specialized services, or ultra-specialized services. However, in this thesis, I focus on CPs working full-time in primary care only. The reason for doing this is two-fold. First, the organizational change under investigation is the implementation of interdisciplinary teams. This change is part of the 2005-MHR that specifically targeted primary care. As such, CPs in primary care have first-hand experience of the change under consideration. Second, part-time CPs work fewer hours, and if they use that time to rest and recover from exhaustion, it can mask the impact of job demands on burnout. On the other hand, CPs working full-time are more likely to experience the full scope of job demands (including workload, responsibilities, and performance expectations) associated with this change.

To recruit the participants for the project, I developed a comprehensive recruitment strategy with several tactics. First, I prepared the communication materials, including a website that I developed from the ground up. Next, I produced a three-minute-long recruitment video in which Dr. Andrew Ryder and I introduced the research project, its relevance, and an overview of the participation process. In addition, I created a series of six informational PowerPoint presentations on the organization of the healthcare system in Quebec, an overview of the reforms under study, and the theoretical framework used to evaluate wellbeing, among others. I embedded these presentations as videos on the website. In addition to conferring legitimacy, the goal of the communication materials was to create an interactive learning product with which the participants could engage with enjoyably.

Besides the online communication product, I drafted recruitment letters in both official languages. I introduced myself and the project in the letter, outlined the participant engagement process, identified the thesis committee, and included a statement on the study's ethics approval. I also had my contact information and the website address included in the letter. I informed them about the study's snowball sampling technique (where potential participants nominate other participants who meet the eligibility criteria through their social networks).

My second tactic was to reach out to local CPs through my professional and social network. Through this avenue, I secured a list of CPs working in the CIUSSS across the five

territories on the island of Montreal. I contacted each person on that list separately with a personalized recruitment letter. My third tactic involved reaching out to the Ordre des Psychologues du Québec (OPQ) and leveraging their policy on supporting research. It was a lengthy process, but the OPQ's administration was very willing. They sent an email with the recruitment letter to all registered psychologists in Quebec through their distribution list and invited them to participate in the study.

After the OPQ and I sent the recruitment messages, the CPs interested in participating in the study contacted me via email and telephone. I reviewed the list of potential participants with the research coordinator on the project, whose responsibilities included conducting the interviews in French, communicating with participants and screening them over the telephone by confirming that they worked in the public healthcare system. If they met the inclusion criteria, the research coordinator booked the date and time for the interview, as well as their preference for interview channel (in-person at their office, over Skype or telephone). For in-person interviews, she noted the meeting location address as well. Finally, to protect participant's identity, the research coordinator also co-created an identification code by using: the last letter of their first name, last letter of their family name, day of the month they were born in, last letter of their mother's first name, and the last letter of your mother's original family name (maiden name). The research coordinator stored this information on a password-protected excel file, which in turn, was saved on a secure password-protected USB key.

A week before the interview date, the research coordinator emailed the participants the link to an online questionnaire and requested that they complete it at least one day before the interview. The interviewer reviewed the response to this questionnaire before the hour-long interview. Finally, if some clarification was required from the participant about what they said in the interview, the research coordinator followed up with them over email or telephone. Participants were compensated for their time with a ninety-dollar amazon gift card.

Measures

Pre-interview Questionnaire: The pre-interview questionnaire verified that the participant met the inclusion criteria and sought their consent to participate electronically (see Appendix A-1). Next, they answered a series of eight questions, including gender, years of professional experience, employment status, healthcare (employment) setting, team-setting, number of professionals on the team, and their caseload. Altogether, these questions informed the participant's professional profile outlined in the Results chapter.

Semi-structured Interviews:

The research coordinator and I conducted the interviews. Out of eight interviews, I administered one in person and the research coordinator conducted the remaining seven either in person or over the telephone (depending the participant's preference). The interviews were recorded using an audio recorder with participant's consent and altogether we had one recording in English and seven in French. Moreover, we used the semi-structured interview protocol, which I had developed, to systematically elicit the job demands and resources associated with interdisciplinary teamwork from each participant (see Appendix A-2).

During the interview protocol development stage, I reflected on its structure and designed it to make the task of analyzing data more manageable. This consideration led me to divide the interview into discrete sections and embed identical probes in similar sections. The decision to elicit participants' responses to targeted questions aligned with my approach to generating realist knowledge and capturing their professional experiences. In this regard, the probes ensured that each participant had an equal opportunity to consider and share their perspective by responding to the question.

Specifically, I divided the interview into five sections, covering the following topics: interdisciplinary teamwork, shared-care, best practices, and wellbeing. Then, I split the interdisciplinary teamwork, shared-care, and quality best-practices into two subsections, i.e., demands and resources. In this way, I systematically asked the participants to respond to the job-demands and -resources associated with each of the three MH-Reform objectives. For example, I included one central question, two probes, and a final question in the subsection on the interdisciplinary team demands. The main question read: '*what are the demanding aspects of working in an interdisciplinary team?*'—followed by the first probe: '*over the long term, which of these demands required additional effort on your part?*'. Then the second probe: '*do you consider these to be hindrances or challenges?*'. And the final question: '*what resources are lacking that makes it difficult to work in interdisciplinary teams*?'.

Similarly, the subsection on interdisciplinary team resources included one central question, two probes, and a final question. The main question read: '*what functional resources are available to you that enables you to work in interdisciplinary teams* effectively?'. Followed by the first probe: '*are there aspects of working in an interdisciplinary team that motivate you?*'. Then the second probe: '*are there aspects of working in an interdisciplinary team that stimulate personal growth or professional development*?'. And the final question: '*are there any other resources we haven't discussed that make it easier to work in a team?'*. I applied this question structure on demands and resources linked to the other two reform objectives involving shared-care and best-practices.

Lastly, I added three questions in the section on wellbeing. The first question inquired: '*How is it affecting your work with clients?*'; followed by: *'What impact has it had on your wellbeing?';* and finally: '*How has it affected your job satisfaction?*'.

After I developed the interview, I piloted it to assess the phrasing of the questions and the flow from one section to another. The test sample included three research assistants from Culture Health and Personality lab, Dr. Andrew Ryder and Dr. Nathalie Dinh. Their feedback helped tremendously to make the questions sound more natural. More specifically, Dr. Ryder's suggestion to articulate *prompts* was especially helpful in nudging the conversation when participants were unsure and sought clarification. The prompt also helped alleviate the interviewers' anxieties in those uncertain moments and ensured they offered the same generic nudge to all participants. Dr. Dinh's recommendation to provide a placemat with definitions (of job demands and resources) to participants ahead of the interview also guaranteed that they did not have to worry about recalling various aspects of job demands and resources. Finally, as noted above, I developed the interview protocol for a larger research project. However, in this thesis, I focused only on one reform objective, i.e., demands and resources associated with interdisciplinary teamwork and its impact on the wellbeing of CPs.

Data set for the thesis project

The Data corpus for this *research project* consists of audio interviews from twenty-four CPs working in Quebec's publicly funded healthcare system. It also includes their responses to an online questionnaire, which they completed before the interview. The data set for this thesis includes eight audio interviews from CPs working full-time in primary care and their responses to the online questionnaire. I referred to them as P1, P8, P10, P13, P14, P15, P18, and P20. The interviews were conducted in both official languages (seven in French and one in English).

Preparing Dataset for Analysis

The audio recordings of verbal data were transcribed into written text by six research assistants from Dr. Andrew Ryder's Culture Health and Personality lab. I reviewed the transcription protocol with each volunteer before they transcribed the data. To develop the transcription protocol, I adapted the guidelines to transcribe the SLX Corpus of Classic Sociolinguistic interviews (2003). It met the minimum requirement of a thorough and meticulous orthographic transcript, including a verbatim account of all verbal and non-verbal utterances such as pauses, laughter, crying, sighing etc.

To prepare the dataset for analysis, I imported the interview transcripts of the eight participants into NVIVO. Next, under 'case classification', I set up a 'case node' for each participant and created their profiles by assigning the following attributes: gender, experience, employment status, and average caseload. In NVivo, a 'node' is a collection of references about a specific case or theme. Case nodes represent 'units of observation' (i.e., interview transcripts), whereas a theme node is a collection of references about a specific theme, concept, or experience.

Creating units of observation as case nodes had several advantages. It allowed me to group two data sources (interview transcripts and pre-interview survey responses) for each participant, query demographic information using the matrix coding query and compare the participants' comments based on gender (for example). Third, it allowed me to visualize the dataset based on attribute values and check the demographic spread of the participants.

Approach to Thematic Analysis

After classifying cases, I followed Braun and Clarke's (2006) step-by-step guide to conduct the thematic analysis. Even though the authors organized their approach into discrete phases, it was not a linear process. I constantly went back and forth between the items in the data set, the coded data extracts, and the analysis itself.

Phase 1: Familiarizing myself with the data In phase-1, I actively listened to the audio recordings at least twice and read the transcribed data alongside each time. First, I listened to the audio recordings at half speed due to my limited proficiency in French to become familiar with the content and to verify the transcripts' accuracy against the original audio recordings. At this stage, I also developed an approach to include the meanings of unfamiliar words and idiosyncratic Quebecoise expressions as annotations in NVIVO. This technique allowed to quickly recall the meaning of words by simply placing the mouse arrow on the text excerpts in NVIVO. To translate the text, I used the following three resources:

Reverso translation (Reverso, 2020), Google translate (Google Translate, 2020) and Je-Parle-Québécois (Les expressions québécoises, 2020) for expressions specific to Québec.

The second time around, I highlighted all instances where the participants talked about topics relevant to the research question. It included all data extracts, where participants discussed the demands and resources associated with working in interdisciplinary teams and its impact on their wellbeing. For example, anytime participants talked about the job-demands related to interdisciplinary teamwork, I highlighted the extract and coded it as 'TD' (Team Demands).

This phase was very time-consuming, mainly due to the coding process, but it was also the foundation of the analysis (Braun & Clarke, 2006). Therefore, I took my time and read each data item in the dataset in its entirety, including the sections outside the scope of this thesis (for example, 'Cultural and Linguistic Diversity in Clinical Practice'). I did this to ensure that I did not miss any data extracts in which the participants talked about topics relevant to the research question. Once I felt adequately familiar with the data set, I moved on to the next phase and began the formal coding process.

Phase 2: generating initial codes As noted earlier, I took a deductive(theoretical) approach to identify themes and used the revised Job Demand-Resource (JD-R) model to code and interpret the data. The logic of the coding framework is rooted in the design of the semi-structured interview.

According to Braun and Clarke (2012, p. 61), codes are the 'building blocks' of the analysis. The authors used a brick house analogy to explain that if the thematic analysis is like a house, then codes are like individual bricks and tiles, and themes are like walls and roof. In other words, a code is the most basic element of the raw data that can be 'assessed in a meaningful way' to understand the phenomenon under study (Boyatzis, 1998, p. 63). Therefore, coding is the process of organizing the data into meaningful groups (Tuckett, 2005).

In the context of this project, I identified codes at the semantic level and did not look for meaning beyond the participants' stated words. Also, I conducted this thematic analysis within the realist paradigm, which assumes that 'language reflects and enables us to articulate meaning and experience' (Braun & Clarke, 2006, p. 85). Additionally, I took a deductive (theoretical) approach to identify the themes and used the revised Job Demand-Resource (JD-R) model to design the semi-structured interview and used the logic of that structure to develop the coding framework.

Next, I created a list of initial codes from the coding framework in NVIVO. For example, the demands associated with interdisciplinary teamwork were labelled 'Team Demands', and this code was classified as the parent node 'TD' in NVivo. Under this parent node, nine sub or child nodes captured different aspects of demands associated with interdisciplinary teamwork (Table 1).

The first four child-nodes (TD-Phy, TD-Psy, TD-Soc, and TD-Org) were linked to the central question in the subsection on demands associated with interdisciplinary teamwork. These child nodes came from Schaufeli and Taris's (2004) definition of job demands, which they articulated as negatively valued job characteristics that required sustained effort. These characteristics could be physical (manual tasks necessary to do the job), psychological

Team Demands (TD)	
1: TD-Phy: physical team demands.	6: TD-Hind: team demands, hindrances.
2: TD-Psy: psychological team demands.	7: TD-Chal: team demands, challenging
3: TD-Soc: team demands that are social.	8: TD-RL: team demands, lack of resources
4: TD-Org: organizational team demands.	9: TD-Oth: other team demands
5: TD-AE: team demands, additional effort.	

Table 1: Team Demands Node Structure

(cognitive & emotional), social (interpersonal), or organizational (physical working conditions). The fifth child-node (TD-AE) was linked to the first probe in the subsection on demands associated with interdisciplinary teamwork. It captured the demands that continually required additional effort. The reason for including this node was linked to Schaufeli & Taris' (2004) explanation that job demands in and of themselves are not negative; instead, they become a source of stress when they require continuous effort. The inclusion of the node TD-AE would allow me to separate regular job demands from those that contributed to burnout.

The sixth and seventh child-nodes were linked to the second probe in the subsection on demands associated with interdisciplinary teams. Together, they differentiated job demands perceived as challenges (TD-Chal) from those perceived as hindrances (TD-Hind). This distinction was based on Crawford, LePine, and Rich's (2010) empirically validated theoretical extension of the JD-R model. According to these authors, challenges are stressful demands that can 'promote mastery, personal growth, or future gains'. In contrast, hindrances are stressful demands that can 'thwart personal growth, learning, and goal attainment' (Crawford et al., 2010, p. 836). Results from their 46-sample meta-analysis indicated that both hindrances and challenges are positively linked to burnout; however, hindrances are negatively related to engagement, but challenges are related positively to engagement. The eighth child node was linked to the final question in the subsection on demands associated with interdisciplinary teamwork; it captured resources that were lacking (TD-RL) and made it challenging to work in multidisciplinary teams. Schaufeli and Taris (2014) argued that lack of resources could be understood as job-demands. For example, in a resource-poor environment, employees must put more effort into achieving their work objectives. This interpretation of job demands was interesting because it prompted participants to consider job demands from a different perspective. Finally, the ninth child-node was not linked to any question in the protocol. Still, I included it to capture all other demands (TD-Oth) that did not fit into any previously discussed eight categories.

For the resources, I coded the resources available to work effectively in interdisciplinary teams as 'Team-Resources' (TR), and this code was categorized as a parent node in NVivo. Under this parent node, four sub or child nodes captured different types of resources associated with interdisciplinary teamwork (Table 2). The first three child-nodes

Team-Resources (TR)	
1: TR-Func: functional resources	3: TR-PD: professional development
2: TR-Motiv: motivating resources	4: TR-Oth: any

Table 2: Ream Resources Node Structure

(TR-Func, TR-Motiv, TR-PD) were linked to the central question and the two probes in the subsection on resources associated with interdisciplinary teamwork. As with team demands (TD), these child nodes also came from Schaufeli and Taris's (2014) definition of job resources, which they defined as positively valued job characteristics that are: (i) functional in achieving work goals; (ii) satisfy the human need for connection; (iii) stimulate learning and professional development.

The fourth child-node (TR-Oth) was linked to the final question in the subsection and captured any other resources that made it easier to work in an interdisciplinary team. Besides job demands and resources, the coding framework in NVIVO included one additional parent node, 'Well-being' (WB). There were three child-nodes (i.e., WB-C, WB-S, WB-Sat) associated with the 'Wellbeing' (WB) parent-node and they were linked to the three questions that covered the impact of reform objective on (i) CPs' work with their clients, (ii) their wellbeing, (iii) and their job satisfaction.

Once I had a list of codes, I systematically went through each case in NVIVO, and identified and tagged (i.e. code) the data extracts where the participants discussed the demands and resources associated with interdisciplinary teamwork and the status of their wellbeing. For example, I coded interdisciplinary team demands as TD, resources as TR, and the Wellbeing status as WB-S. During this process, I gave equal attention to each data item and made sure that I coded all relevant extracts within it before moving on to the next one. Plus, I followed Braun and Clarke's (2006) advice and coded the data extracts inclusively; meaning, I tagged the excerpts under more than one code where it was relevant and included some of the surrounding text to capture context. Finally, I did not ignore the accounts of inconsistencies and contradictions within and across data items. By adopting these tactics, I am confident that I reliably coded the content linked to the interdisciplinary team demands and -resources, as the impact of this reform objective on the wellbeing of CPs.

Next, I created an attribute variable called 'Burnout Level' in the 'Participant Profile' under case classification and created three categories for it: (A) full-on burnout; (B) some features of burnout; (C) no burnout. Then, I ran a 'coding' query to collate the data excerpts on WB-S and reviewed them to identify the participant's level of burnout. CPs that explicitly stated that they 'experienced burnout' were classified under 'A'; those that experienced 'stress' or at least one of the three features of burnout (namely: exhaustion, feelings of depersonalization, diminished sense of personal responsibility) were classified under 'B'; and finally, those that did not mention burnout, stress, or any of the three features of burnout were classified under 'C '.

Phase 3: Searching for themes In phase 3, I shifted the focus of my analysis from codes to themes. According to Braun & Clarke (2006, p. 82), themes capture 'something important about the data in relation to the research question and represent some level of patterned responses .'To search for patterns in the participants' responses grouped by their level of burnout (i.e., no burnout, some burnout, full-on burnout), I ran a 'crosstab' query to collate the data excerpts coded as TD and TR. And I exported it as a Word document to analyze the content. Based on this approach, I grouped: P1, P10, P14 under 'A'; P13, P15, P18 under 'B', and P8, P20 under 'C'. Next, I copied the translated interview transcript of three groups into OneNote to look for patterns (Appendix C).

When I first looked for patterns, I organized the excerpts within each group based on the type of demand (i.e. physical, psychological, social, etc.) and resources (i.e., functional, motivation, professional development, and other). I intuited that it would be easier to identify patterns if I categorized the excerpts in this way. And while this approach to organizing excerpts was relatively straightforward for TR, I became stalled when I tried to identify themes that met Patton's internal homogeneity and external heterogeneity criteria for TD. After reflecting on it for a few days, I abandoned the idea of groupings based on the type of demand/resource, and I pursued a different approach that involved identifying patterns in discrete units of meanings within the excerpts. So, I went back and systematically analyzed each extract and looked for topics discussed within it to segment them into discrete units of meanings. In this way, I developed a hybrid 'V' approach that merged top-down and bottom-up approaches. For example, in the Burnout group, P-10 reported the following in response to a probe on whether attending mandatory off-site meetings among psychologists required additional effort (AE):

> P-10_R7_TD-AE[1]: the meetings are less pleasant because they are outside, and we all must travel. And these are the meetings that all psychologists in the CIUSSS Capitale-Nationale region must attend. We don't know each other. So, it's hard to support each other. We go to meetings; it revolves a lot around questions about what is coming. But we don't have the opportunity to offer each other our own support. No, it doesn't exist anymore; it's like private. But we have access to all the schools in the CISSS Capitale-Nationale region.

In reviewing this excerpt, I noted that P-10 brought up two things: professional group meetings among psychologists are inconvenient because they are held off-site, and there is a lack of professional support because they don't know each other, so it feels like in private. It led me to identify two topics: (i) off-site meetings are inconvenient, and (ii) there is a lack of professional support at mandatory meetings among CPs. To capture this information visually, I summarized the excerpt in text bubbles and labelled it as follows (Figure 6):

Creating a visual representation of discrete topics for TD and TR as bubbles allowed me to create a mind-map. It also enabled me to easily move them around. This process was very challenging. I reshuffled codes and organized them in different configurations. I looked for areas of similarity and issues around which codes clustered and actively generated themes

[1] (NB: The label **P-10_R7A_TD-Org** means that the P-10's transcribed words can be found under Reference 7 in the document titled FT-PC_Exp-Burnout [TD]. The code TD-Org refers to organizational demands associated with working in interdisciplinary teams)

by examining the relationships between codes, themes, and between different levels of themes (i.e., main overarching themes and sub-themes within them).

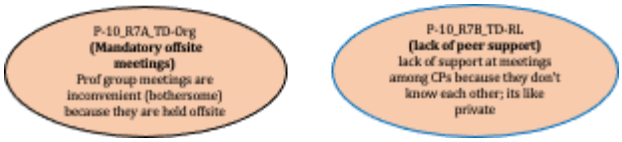


Figure 6: Text-bubble example

Phase 4: Reviewing themes Phase 4 involved the refinement of the themes at two levels. First, I reviewed the coded data extracts within each theme and examined whether they formed a coherent pattern. I used Patton's (1990) criterion of internal homogeneity to evaluate the excerpts. If they cohered together, I moved on to the second level of the refinement phase; otherwise, I continued my analysis at this level and investigated whether the problem was with articulating the theme itself or whether the data extracts within it did not fit. I reworked the theme or created a new one if it was the former. Otherwise, I relocated the extracts that did not fit to another more appropriate theme; or discarded them from the analysis. Altogether, I excluded five codes (text-bubbles). Once I was satisfied that the themes 'adequately capture[d] the contours of the coded data' (Braun & Clarke, 2006, p. 91), I moved on to level two of the refinement phase.

At level two, I followed a similar process as in level one. But instead of reviewing the coded data extracts, I employed Patton's (1990) second criterion of external heterogeneity to examine the validity of each theme in relation to the entire data set and whether there were 'clear and identifiable' differences among them (Braun & Clarke, 2006, p. 91). I also evaluated whether my hypothesized thematic map *accurately represented* the meanings in the entire dataset (i.e., whether the themes worked together in relation to the dataset). Braun & Clarke (2006, p. 91) specified that 'accurate representation' depended on the researcher's theoretical and analytical approach, which for this project included a theory-driven realist thematic analysis aimed at providing a detailed description of the entire dataset. At the end of this process, I identified six themes that captured the demanding aspects of working in interdisciplinary teams and five portraying job-resources that enabled interdisciplinary teamwork.

Phase 5: defining and naming themes In phase 5, I focused on defining and refining the themes I included in the final analysis and reviewed the data within them. Essentially, this fine-tuning process involved figuring out the gist of each theme and organizing the aggregated data extracts within it into a 'coherent and internally consistent' narrative. In doing so, I made sure that my analysis went beyond merely paraphrasing the content and examined what was interesting about it and why. Next, to ensure that there was not too much overlap among themes, I kept an eye on articulating the narrative of each theme and how it connected to the overall story in relation to my research question. At the same time, I was also mindful of the scope of each theme because Braun & Clarke (2006, p. 92) emphasized that 'it is important not to try and get a theme to do too much'. If the theme was too 'diverse and complex', I investigated whether it contained any sub-themes and used them to give it structure or show a 'hierarchy of meaning' within the data.

At the end of this phase, the six themes describing the demanding aspects of working in interdisciplinary teams included *Organizational aspects of interdisciplinary teamwork, Role Creep, Organization's Internal Environment, Increase in Job-Tasks, Inadequate Human-Resources (HR), Inadequate Support*. The third theme (*Organization's Internal Environment*) encompassed two sub-themes (*Physical Environment and Organizational Climate*). I organized the themes around the three areas of work-life proposed by Leiter and Maslach (2004): Workload, Control, and Community (Table 3). Similarly, the 5 five themes capturing the job-resources included *HR, Planned Interdisciplinary Meetings, Co-Location, Social Support, Knowledge-Exchange*. The first theme (*HR*) incorporated two sub-themes (*Specialized HR and Administrative HR*). The five themes were grouped under three types of job-resources, i.e. resources that are: functional in achieving work goals, satisfying the human need for connection, stimulating learning and development (Job Resources).

Phase 6: producing the report I analyzed the text within and across themes and wrote up the final analysis at this stage. In the report, I attempted to create an exciting account of the story that the data told with clear examples in a 'concise, coherent, logical, and non-repetitive manner (Braun & Clarke, 2006, p. 93). Ultimately, my goal was to tell the complex story of the data to convince the reader of the rigour and quality of the analysis. I provided evidence (data extracts) that adequately substantiated the prevalence of themes and embedded them within an analytic narrative that went beyond the description of the data and made a compelling argument in relation to the research question.

Work Area	Control Problems					Workload		Organizational Community
Theme	**The Organizational aspects of inter-disciplinary teamwork**	**Role Creep**	**Organization's Internal Environment**			**Increase in Job Tasks**	**Inadequate HR**	**Inadequate support**
Subtheme			Physical Environment	Organizational Climate				
Sub-subtheme				*Role Overload*	*Role Conflict*			
P-1	X	X				X		X
P-10	X	X				X	X	X
P-14		X	X	X	X	X	X	X
P-13	X					X		
P-15	X						X	X
P-18	X							
P-8								
P-20	X					X		

Table 3: Job Demands

Resource Type	Functional Resources				Motivate	Learning & Professional Development
	Human Resources		Planned Interdisciplinary Meetings	Co-Location	Social Support	Knowledge Exchange
Theme	Specialized Human Resources: Mental Health Professionals	Administrative Human Resources				
P-1	X		X		X	X
P-10	X	X	X		X	X
P-14		X	X	X	X	X
P-13	X		X	X	X	X
P-15					X	X
P-18	X	X	X		X	X
P-8		X			X	X
P-20	X		X	X	X	X

Table 4: Job Resources

Results

This chapter summarizes the results of that analysis. The first section outlines the participants' professional and burnout profiles, followed by themes capturing the job demands and resources associated with interdisciplinary teamwork.

Participants' Professional and Burnout Profile

A total of eight participants (N = 8) met the inclusion criteria of full-time clinical psychologists working full-time in primary care across the five health regions in Quebec (Figure 7; p. 27). The interviews were conducted in-person and over the telephone. Seven of these interviews were conducted in French and one in English, and they were recorded using an audio recorder with the participants' consent. I was unable to establish saturation because there were only two participants in the 'no burnout' group (G3) and three each in the groups that 'experienced burn out' (G1) and 'some symptoms of burnt out' (G2). Despite this limitation, the analysis provides rich insights into the organizational correlates of burnout through the lens of demands linked to interdisciplinary teamwork in primary care and available resources to meet those demands.

I created the participant profile (Table 5; p.28) based on the responses from the online pre-interview questionnaire that the participants completed before the semi-structured interview (see Appendix A-1). Next, I created a burnout profile based on the approach outlined in the process section of the Methodology chapter. I addressed the first research question: What was the level of burnout in the sample (RQ-1)?

G1 (experienced burnout)

Participant 1 (P1) identified as female and conducted the interview in English. She worked in the CIUSSS du Centre-Ouest-de-l'Île-de-Montréal, which is part of the Montreal Health Region. P1 had 20 years of experience, worked full time in an adult mental health team. Her team had 9 mental health professionals and she had an average caseload of 18 patients.

When describing the state of her wellbeing, P1 stated that she had burned out. Things had changed since the reform, and '[they] were in a different paradigm'. There were too many changes to 'adapt' to. Her team was doing their best, but they felt that it was 'never enough' (R4). There was a discrepancy between what they thought was meaningful work (i.e. helping clients) and what the management seemed to be looking for (quantifiable output) (R1). The two were not 'speaking the same language' (R1). P1 coped with the change by 'block[ing] things' and tried not to 'ruminate' (R1).

P1 felt that she was not 'valued', lacked 'autonomy', was not 'respected' for her work, and had to 'justify a lot of things' (like training), which made her feel like the management didn't trust her (R1,2,4). She was not sleeping and crying all the time (R4). One day, she was so emotionally overwhelmed that she 'cried in a meeting', but the manager didn't acknowledge her and insisted to 'focus on the group project' (R4). It was a tipping point for her, and she took a ten-day sick leave (R4).

Participant 10 (P10) identified as female and conducted the interview in French. She worked in the CIUSSS Levis, which is part of the Chaudière-Appalaches Health Region. P10 had 2.5 years of experience, worked full time in a Children Youth & Family Mental Health

team. Her team had 13 mental health professionals and she had an average caseload of 23 patients.

P10 was diagnosed with major depression and burnout within a year of working at a CLSC. In addition to her caseload, P10 had to work with her doors open so that she could support her colleagues. It was 'too much'. Once depressed, P10 found it hard to recover from it. She had a tough time with it because she treated clients with depression and didn't see it coming ('like a hair in a soup'). It impacted her confidence in herself as a professional (R1). Since recovering from burnout, P10 was on the lookout for when she felt tired and took time off ('health day') to rest (R4). Despite the problematic brush with burnout, P10 liked her job and working with young people. Also, she loved working in a team, and even though they did not work as a team every day, she knew that they were there when she needed them (R8).

Participant 14 (P14) identified as female and conducted the interview in French. She worked in the CIUSSS du Centre-Sud-de-l'Île-de-Montréal, which is part of the Montreal Health Region. P14 had 3 years of experience, worked full time in a Youth Mental Health team. Her team had 10 mental health professionals and she had an average caseload of 22 patients.

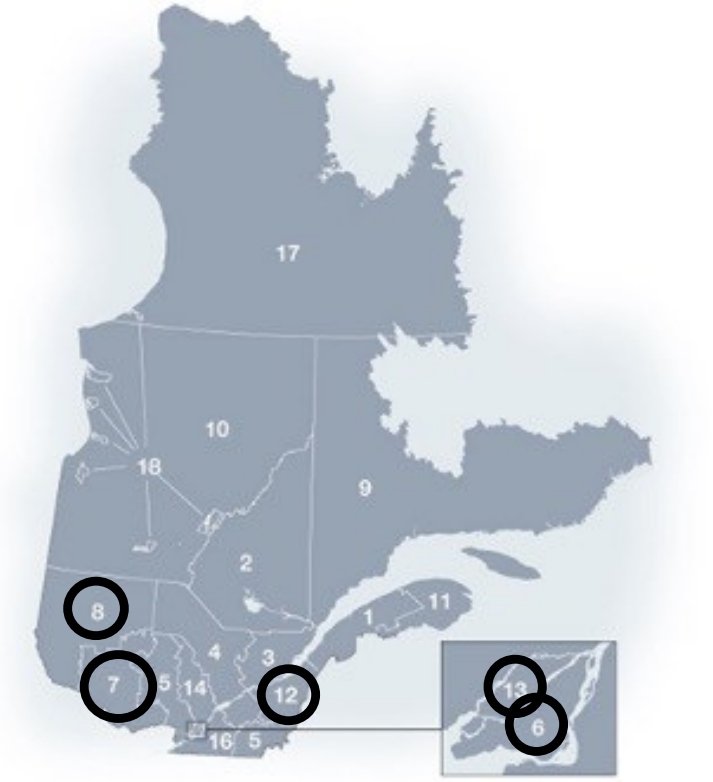
P14 had been working in the network for a year and was experiencing 'symptoms of burnout'. But she toughed it out and continued to work while looking for work elsewhere. In Dec 2018, P14 had a 'serious concussion' at the gym and lost her 'cognitive abilities' for months. This accident 'triggered a shutdown in her body,' and it took time for her 'brain to recover'. P14 attributed the accident to 'chronic stress' and 'exhaustion' (R1).

P14 felt that her experience would have been 'less overwhelming' had it not been for all the 'interdisciplinary partners' issues. She 'felt stuck', and it was difficult because she was 'involved in the (day-to-day) life of the child'. Plus, the 'confusion about her role' complicated things (R2).

For example, P14 explained that the school managed the crisis (with the child) daily, but sometimes when they couldn't handle it, they would call her. In these situations, she 'accompanied' the social worker because she felt that she was 'supposed to be there for the child' and would try to offer some 'therapeutic space' away from the 'chaos and conflict'. But the social worker had to meet with 'distressed parents', and in this way, P14 would get 'caught up in the distress of the parents' as well. It was tough because a lot of her role was 'at the level of contact with partners,' but when parents 'got involved in the conflict, it violated the therapeutic space' that she was trying to offer to the child. All of this was happening while P14 was attempting to develop her skills as a young therapist (R2).

P14 noted that providing good mental health treatment to a child is 'hard and complex'; she had 'so many other things to do' that 'her role as a therapist finally took her to the edge'. Furthermore, the organization did everything in a' rushed' way, and she 'didn't have time to think'. When she was 'not in a therapy with a client, she was busy elsewhere'. And 'if the child is in your care for a long time and they were not getting better, then the boss started asking questions' (R-2). In this way, the 'cycle of stress continued' (R2).

Participants - Health Region (HR)



Montreal (HR:6; population density: 3769.1 people per km^2)
- P1 (Centre-West); P14 (Centre-South)

Abitibi-Témiscamingue (HR:8; population density: 2.5 people per km^2)
- P15, P18 (Rouyn-Noranda)

Outaouais (HR:7; population density: 11.5 people per km^2)
- P13, P20 (Gatineau)

Chaudière-Appalaches (HR:12; population density: 11.5 people per km^2)
- P10 (Levis)

Laval (HR:13; population density: 1562 people per km^2)
- P8

Figure 7: Participants' Health Region

Burn-out Level	ID	Gender	Language	Experience	Employment Status	Health-care Setting	PC Team Setting	Average Caseload
G1: Experienced burnout	1	F	EN	20	FT	PC	Adult MH	18
	10	F	FR	2.5	FT	PC	Children Youth & Family	20-25
	14	F	FR	3	FT	PC	Youth MH	22
G2: Experienced some symptoms of burnout	13	F	FR	3	FT	PC	Adult MH	30
	15	F	FR	2	FT	PC	Youth MH	18
	18	F	FR	1	FT	PC	Adult MH	20
G3: Did not experience burnout	8	F	FR	35	FT	PC	Youth MH	25
	20	F	FR	5	FT	PC	Adult MH	37

Table 5: Participants' professional profile

G2 (experienced some symptoms of burnout)

Participant 13 (P13) identified as female and conducted the interview in French. She worked in the CIUSSS Gatineau, which is part of the Outaouais Health Region. P13 had 3 years of experience, worked full time in an Adult Mental Health team. Her team had 24 mental health professionals and she had an average caseload of 30 patients.

P13 found some aspects of interactions with management 'exhausting' and that impacted her well-being but 'not in a dramatic way'. For example, the director and three managers in P13's organization were all social workers. And there were times when they had 'certain expectations', but they 'misunderstood' what a psychologist could do. So, she had to bring out the 'code of ethics' to demonstrate what she could and couldn't do. P13 felt she had to take 'additional steps to be heard' (R1).

Plus, there were 'many changes', and she 'didn't have time to adjust' or 'think about what was going on' but managing management's expectations and adapting to changes required additional energy. As a result, P13 was exhausted, but it was manageable. Sometimes, she wondered whether she was going to stay with the team because of the pressure and was tempted to look for a job elsewhere (R1).

Participant 15 (P15) identified as female and conducted the interview in French. She worked in the CIUSSS Rouyn-Noranda, which is part of the Abitibi-Témiscamingue Health Region. P15 had 2 years of experience, worked full time in a Youth Mental Health team. Her team had 7 mental health professionals and she had an average caseload of 18 patients.

In describing the status of her wellbeing, P15 felt that she assumed more responsibility for each patient and found it 'harder to let go' at the end of the day. Sometimes it was difficult to 'think of something else', and as a result, she felt tired. Some days, she was 'less motivated' to go to work or 'less interested [ed] in starting a new file' because it was sometimes 'less pleasant' (R1).

Participant 18 (P18) identified as female and conducted the interview in French. She worked in the CIUSSS Rouyn-Noranda, which is part of the Abitibi-Témiscamingue Health Region. P18 had 1 year of experience, worked full time in an Adult Mental Health team. Her team had 17 mental health professionals and she had an average caseload of 20 patients.

P18 felt 'helpless' when she was 'confronted' with the 'failures [and] weaknesses' of the system, including 'lack of access to services' and 'inability to give more services to people that need[ed] them'. As a psychologist, she had to 'do a lot of [administrative] things in a short period, while people were suffering in front of her that need[ed] access to services'. What's more, all the 'additional steps that [were] required to provide mental health services [were] in addition to the reports' she had to write and the consultations she had to do with the doctors. The workload was not 'realistic given the time and clientele' she had. It was a 'load to carry' and was 'exhausting' (R1).

G3 (no burnout):

Participant 8 (P8) identified as female and conducted the interview in French. She worked in the CIUSSS Laval, which is part of the Laval? Health Region. P8 had 35 years of experience, worked full time in a Youth Mental Health team. Her team had 26 mental health

professionals and she had an average caseload of 25 patients. P8 was a registered CP but was working as a clinical coordinator and did not see clients for therapy.

P8 described the impact of working in primary care as 'heavy' (R1). Clinicians could still work with their approaches, but a 'lot of tasks' had to be done in a day, including 'performance requirements such as taking in patients within 30 days and conducting a minimum number of three interviews per day'. The reforms had 'put a lot of pressure', but they had made 'great progress [towards] working in a network and collaborating, which was stimulating and motivating'. It was demanding work, but it required that you 'believe[d]' in interdisciplinary work and be motivated' (R1).Besides the performance requirements, the 'clientele [was also] growing and they [were] presenting significant clinical challenges'(R1). For example, 'transgender kids, children with multiple diagnostics, developmental disabilities, mental health issues, families with [migration] history or [trauma]'). There was a 'lot of work,' and it had become 'heavier' (R1)

P8 worked 'thirty-five hours per week', and during this time, she interacted with multiple stakeholders and was 'busy from start to finish' (R5). But once the work was 'over' (R6). She worked nights only if she was 'required' to but respected her 'limits' and generally did not. P8 'took active steps to have a healthy work-life balance' and gave herself the 'means to maintain it by ... prioritizing, asking for help, and trusting people she worked with' (R5). She had a 'positive attitude towards collaboration,' which was at the 'heart' of her practice. She believed that interdisciplinary work took one farther than alone (R5). Finally, she professionally supported herself and sought 'supervision' and training if she needed it (R6).

Participant 20 (P20) identified as female and conducted the interview in French. She worked in the CIUSSS Gatineau, which is part of the Outaouais Health Region. P20 had 5 years of experience, worked full time in an Adult Mental Health team. Her team had 7 mental health professionals and she had an average caseload of 37 patients.

When discussing her well-being, P20 noted that 'one of the biggest irritants' in her work was that they had many reports to write compared to what a psychologist does in a private setting. The management was asking for a 'lot of writing', which was an 'irritant' because they saw 'fewer clients' at the end of the day (R1). She felt 'exhausted' and reported that they were doing 'many unnecessary things' but still had to do. There was 'too much administrative' work, and it 'distracted her from the primary objective', which was to 'see clients' and 'to do therapy'. (R3; WBC).

P20 was also upset about the rollout of Quebec's Program for Mental Disorders (PQPTM), which was based on objective measures (validated questionnaires) and 'clinical practice' guidelines that she suspected would be too prescriptive. The PQPTM notes that the guidelines support the clinical judgement of professionals. At the interview, P20 had 'little information about the program', but it' irritated' her when she first heard about it. She perceived that the management would 'impose on [her] a way of working'. She was 'upset' because she felt that she had a 'doctorate' and knew how to do her job (Ref-1; WBS). She wondered how much latitude she would have with the program and how the management would implement it but was exasperated by what she perceived as an encroachment on her autonomy (R2; WBS).

Thematic Results

The following section presents the themes linked to the job demands encountered by the CPs working in interdisciplinary teams (RQ-2), and the job resources to meet those job-demands (RQ-3). The themes include data extracts and participants' quotes to substantiate the themes. Note that the quotes are not participants' exact spoken words because the interviewers conducted the interviews in French. Even though I prioritized using the exact English translation of key ideas discussed in French during translation, I modified the phrasing to fit the flow of the narrative. Furthermore, I used an English equivalent to preserve the meaning in instances where I couldn't find an exact translation of a word or phrase.

Job Demands

All participants were asked about the demanding aspects of working in an interdisciplinary team. And based on my analysis, I identified six themes that represent the organizational correlates of burnout linked to working in an interdisciplinary team. Moreover, the six themes clustered around three (of the six) areas of work-life proposed by Leiter and Maslach (2001). These include Control, Workload, and Community. Table 3 lists the themes and identifies the participants that endorsed each theme.

Control

The themes concerning the organizational aspects of interdisciplinary teamwork, role creep, and the organizational context fit into the work-life area called Control. According to Leiter and Maslach (2003; P. 96), people 'want to have some input into the process of achieving the outcomes for which they will be held accountable'. However, they add 'control problems occur when workers have insufficient authority over their work or are unable to shape the work environment to be consistent with their values'. Based on this, I put forward that the control problems linked to the three themes (organizational aspects of interdisciplinary teamwork, role creep, and the organization's internal environment) contributed to the stress experience of clinical psychologists (CPs) and hurt their sense of efficacy.

Control Problems linked to The Organizational Aspect of Interdisciplinary Work

Six out of eight participants identified a lack of control over the organizational aspects of interdisciplinary teamwork as one of the demanding aspects that contributed to their stress. Among these six participants, two belong to Group-1 (experienced burnout; G1), three to Group-2 (experienced some symptoms of burnout; G2), and one to Group-3 (no burnout; G3). This theme is considered a prevalent theme because at least three participants (1 from each group) discussed this topic.

G1 (experienced burnout): All three participants in G1 identified lack of control over the organizational aspects of interdisciplinary teamwork as one of the demanding aspects that contributed to their stress.

P1 talked about in-depth interdisciplinary group supervision and noted that they used to have 'group supervision', during which they would go deeper into either a 'theme, or topic, or client' (R2). These in-depth interdisciplinary meetings were 'very important' to P1, and she preferred to have them with 'her team' but the management replaced them with intra-

professional meetings. P1 felt that the intra-professional group meetings among CPs were 'inconvenient' because they were held 'off-site', and she had to spend time travelling to the location (R2). Plus, P1 felt that she didn't have a choice because they were 'mandatory' and had to attend even though she was somewhat reluctant (R3).

Like P1, P10 also talked about mandatory intra-professional meetings among CPs and found these meetings inconvenient for the same reason (R7). She also expressed that these meetings were a missed opportunity because they didn't discuss cases or issues concerning MH treatment (R8). Instead, these intra-professional meetings were more like 'information sessions' during which they reviewed topics such as: "What are the services aligned mental health? What changes has the government made? Where are we going? What's coming? What psychologists going to need to be trained?" (R8). P10 felt that it was an unnecessary in-person meeting because it was possible to receive this information by videoconference (R8).

G2 (experienced some symptoms of burnout): All three participants in G2 identified lack of control over the organizational aspects of interdisciplinary teamwork as one of the demanding aspects that contributed to their stress.

Similar to P1, P13 talked about problems planning and coordinating meetings. Given the large number of professionals on the team, she found it challenging to find a time to meet due to scheduling conflicts. She reported in one instance, it 'took three months to organize a meeting with other professionals on the team that was following the same patient (R1). In addition, P13 reported that it was difficult for the teams to meet for 'meetings planned in advance' because there was 'no space' and they were expected to reach out and connect on their own (R2). Eventually, the management addressed the issues of space and time that made it easier for MHPs between primary and specialized services to meet (R8). However, it was still difficult to coordinate and organize these meetings with other health professionals on the team; and P13 noted that having managers' support would be helpful because they have contact with other managers in the CIUSSS (R8).

P15 talked about the lack of interdisciplinary teamwork and noted 'it [was] rare that within her team [she] ... work[ed] with another MHP' (R2). Therefore, the biggest challenge was no interdisciplinary team, and she viewed it as a loss (R2

P18 talked about clinical exchanges and noted that monthly meetings with the GP and respondent psychiatrist were not enough to discuss cases. She elaborated that her team has about twenty people, and so 'when they [met] once a month, several people [had] requests, and they [were] unable to address all of them' (R3).

G3 (no burnout): Only one participant in G3 identified lack of control over the organizational aspects of interdisciplinary teamwork as one of the demanding aspects that contributed to her stress.

P20 talked about her lack of control over her ability to conveniently access resources necessary for her to do her job effectively. Among those barriers, she included access to front-line and psychiatry databases, which created extra for her because she had to physically go to the archives to read the GP's and psychiatrist's notes (R9).

Control Problem linked to Role Creep

Role-creep happens when employees perform tasks outside of their role or agreed upon scope of their job. Control problem linked to role-creep is a non-prevalent but key theme because it captured the G1's perceived lack of control over the scope of their role.

G1 (experienced burnout): All three participants in G1 identified control problems linked to role-creep as one of the demanding aspects of working in an interdisciplinary team that contributed to their stress experience.

P1 talked about role-creep and noted that she was asked to 'run psychoeducation groups' (R7). P1 felt that it underutilized her skills and said, 'technicians could run them ... you don't need professionals ...[or] 'special skills' (R7).

P10 also talked about role-creep and noted that she was asked to work with her office' door open' to 'support social workers and specialized educators' (R3). She said that this extra responsibility - in addition to her 'regular caseload' and mandatory 'administrative tasks' - was 'too much' and it became 'very heavy' (R3).

P14 talked about role-creep and noted that the role of a CPs in a public healthcare system was somewhere between a 'liaison officer and a clinician', but the reform had led them 'too far' in the direction of being a liaison officer (R1). As a liaison officer, she 'accompanied' the social worker because the school at which the child she was treating would sometime call her. P14 felt she was 'supposed to be there for the child' and would try to offer some 'therapeutic space' away from the 'chaos and conflict'. But the social worker had to meet with 'distressed parents', and P14 would get 'caught up in the distress of the parents' as well. '[People] that [were] under distress [felt] like they [could] come to a psychologist' and working in an interdisciplinary context '[felt] as though she was the therapist of social workers and parents' as well (R3).

Control Problems linked to Organization's Internal Environment

According to Gavin and Howe (1975; P. 229), an organization's internal environment is the 'totality of the present organizational state'. It includes 'physical environment' and is 'synonymous with organizational climate'. In this thesis, I have conceptualized an organization's internal environment as its physical environment and organizational climate.

Physical Environment

An organization's physical environment includes all material objects and arrangements of those objects, for example, furnishings, office plans, and ambient conditions such as lighting (Elsbach & Pratt, 2007). Physical Environment is a non-prevalent but key theme because physical surroundings have an impact on client's perception of psychological safety.

Only P14 identified a lack of control over her physical environment as one of the job demands and noted her workspace was 'not very conducive to do therapy' (R6). Specifically, she stated that it was 'small, cold and without any windows', and she had to 'share it with other psychologists' (R7). P14 noted that it didn't make her feel valued (R7).

Organizational Climate

Organizational climate is a multidimensional construct referring to the shared meaning attached to an organization's policies, practices, and measures associated with the employee experience (Schneider, Ehrhart, & Macey, 2013). There are many conceptualizations of organizational climate in the literature, but as per Green and colleagues (2014), I characterize it as role overload and role conflict.

Role Overload characterizes a workplace where employees feel overwhelmed with work (Glisson et al., 2008). It is a non-prevalent but key theme because it captured an important aspect of the organizational culture that was a (shared) lived experience among the employees.

Only P14 from G1 identified role overload as one of the demanding aspects of working in an interdisciplinary team. She noted that 'the problem was bigger than inadequate human resources' (R8). She said that everyone in her team had a 'lot of files' and 'they were caught up in a hellish performance cycle' (R8). Her colleagues dealt with the same 'overflow' and were all 'overwhelmed with work' (R10). 'No one stopped' (R8). There were 'only eight psychologists for the entire south-west territory of Montreal' (R8). P14 concluded by noting that 'even though there was excessive work', it was in a 'compassionate environment,' but there was 'something rotten underneath' (R10). It was difficult to stay sane given the pressures, even though the organizational climate was pleasant.

Role Conflict characterizes a work environment in which 'worker's preferred role is out of sync with important qualities of the job' (Leiter & Maslach, 2004; P. 97). It is a non-prevalent but key theme because concisely captures the difficulties faced by a novice CP in an interdisciplinary community-based practice.

Only P14 from G1 talked about role conflict and said that 'the work of a psychologist is very intimate; it [required] a protected space – like a bubble – in which a patient [was] protected from the tornado of everyday life. The protected space allows the patient to take distance from everyday life and figure out what they [were] going through so that they [could] fix it. But if you [yourself were] caught in a tornado, [then] how can you [help]? Instead, you [were] getting hit by the tornado all the time' (R2). The interdisciplinary work kept her 'closer to the floor', which hurt the therapeutic bubble that [she was] trying to build with the client. P14 identified the community-based practice as one of the demanding aspects of interdisciplinary teamwork because it was 'deeply rooted in the daily life' (R5). She noted that there are 'psychologists that [were] very comfortable with the community-based approach'; but, as a novice psychologist, P14 found it to be 'very difficulty' and 'hard to balance against the work that a psychologist does in a more therapeutic space' (R5).

Workload

The workload is the most fundamental aspect of work life. People experience work overload when they have "too much to do in too little time with too few resources" (Leiter & Maslach, 2004; P. 95). This theme is made up of two sub-themes that are two-sides of the same coin, namely: Increase in Job Tasks and Inadequate Human Resources.

Increase in Job Tasks

Job-Tasks are actions carried out by workers in turning inputs into outputs. Among the eight participants, six talked about increase in job tasks as one of the demanding aspects of working in an interdisciplinary team. An increase in job-task is a prevalent sub-theme because at least one participant from each group discussed this topic.

G1 (experienced burnout): All three participants in G1 reported an increase in job tasks resulting from working in an interdisciplinary team.

P1 identified an increase in job tasks following the 2015 HSR and expressed her frustration with the frequency of directives that came from management. P1 discussed administrative tasks, such as paperwork to refer and noted that this type of work 'took time' (R1). But, it was a formality and 'had to be done'; mainly because she had already discussed the case with her team, and she knew that her 'co-worker [would] take the client' (R1). However, P1 reported in the 'last 3 to 4 years', there was a switch in the governance and the management began to institute 'more and more' mandatory tasks, which added to their workload (R4). For example, intra-professional meetings. These meetings were 'inconvenient' because: (i) they were mandatory, and it was yet another thing they 'had to do among so many that were added [to their workload] in the last three to four years'; and (ii) they were held 'offsite' (R3). Finally, P1 reported that she was asked to 'run psychoeducation groups', which she did willingly. But they were outside the scope of her work and felt that it underutilized her skills as a professional psychologist (R7).

P10 also identified the increase in job tasks as one of the demanding aspects of working in an interdisciplinary team. She noted that she was asked to work with her office' door open' and support colleagues, including 'social workers and specialized educators' (R3). She was expected to do this on top of their regular clinical caseload and administrative work (R3). P10 confided that the mental and emotional labour from meeting the requests of her colleagues was 'too much' and 'it got very heavy' (R2, R4). In addition, she reported that CPs had been 'asked to conduct evaluations for autism spectrum disorder' (R9). Even though P10 perceived the coordination and delivery of this new service as a challenge (rather than a hindrance), she pointed out that it would 'add to the workload' (R9).

P14 also identified the increase in job tasks as one of the demanding aspects of working in interdisciplinary teams. Specifically, she talked about the emotional labour of supporting colleagues and parents and said that there was something about being a psychologist that people who were 'under distress' felt like they could come and talk to (R3). Working in an interdisciplinary context made P14 feel as though she was the therapist of social workers and parents. In addition, 'there was an overflow of administrative tasks required by the CIUSSS' (R9). P14 felt that 'there was a pressure to take on more workload' and an implicit performance demand behind the administrative tasks they had to do (R9).

G2 (experienced some symptoms of burnout): Only P13 from G2 identified the increase in job tasks as one of the demanding aspects of working in interdisciplinary teams. Specifically, she talked about the planning aspect of interdisciplinary teamwork and explained that she took her time to plan whenever she took on a 'new case'. P13 felt it was important to plan at the front end of the engagement because it paid off in how the client

progressed later in their treatment (R5). However, it was a 'challenge to do this in a big team', because planning and coordination took more time due to scheduling conflict (R6).

G3 (no burnout): Finally, only P20 in G3 talked about the increase in job tasks as one of the demanding aspects of working in an interdisciplinary team. P20 identified additional workload that resulted from lack of access to relevant databases as one of the demanding aspects of working in an interdisciplinary team. For example, P20 noted that she 'work[ed] with [the] department of psychiatry but [didn't] have access to their database,' so she had to physically go to the archives to access their notes (R9). She couldn't bring files back to her office, so it wasted her time.

Inadequate HR

Inadequate HR captures the increase in CPs' workload because there aren't enough employees to meet the work demands. Among the eight participants, three reported inadequate human resources as one of the demanding aspects of working in an interdisciplinary team. Among these three participants, two were from G1 and one from G2. Inadequate HR is a 'somewhat' prevalent theme because at least 2 participants from two separate groups discussed this topic.

Group 1 (experienced of burnout): Two out of three participants in the burnout group identified inadequate HR that contributed to their workload. Both P10 and P14 reported a shortage of human resources in their teams; however, their reasons for this shortage were different.

P10 identified inadequate human resources as one of the job-demands linked to interdisciplinary teams. She talked about the job cuts following the 2015 HSR and people going away on leave, which increased her workload. For example, P10 recalled that 'the management eliminated the nurse navigator's position' and 'the psychologist in charge went on maternity leave' (R5,6). The job cuts left P10 and the other CP on her team to take on the workload of two employees, and that is how she became 'overloaded with work' (R5,6).

P14 also identified inadequate human resources as one of the demanding aspects of working in an interdisciplinary team and commented that there was a 'scarcity of psychologists in the CIUSSS' (R4). Specifically, P14 reported that there were only eight CPs on her team, and they served the entire Centre-South territory of Montreal. She added that the general attitude among health professionals in primary care teams was 'okay, we have a psychologist, let's make the most of them' (R4). P14 felt that the lack of CPs contributed to an increase in her workload, which among other things, contributed to her burnout because she expressed that 'with a bigger team,' her team would have felt 'less overwhelmed' (R8).

G2 (experienced some symptoms of burnout): P15 was the only participant in G2 that talked about inadequate HR. Specifically, P15 noted that she was the 'only MHP on her team' with 'no social worker to work on other challenges that a young person may be going through' (R1). She added that there was such a 'shortage of professionals (i.e., occupational/speech therapist) that all the responsibilities fell on one person' (R4). In addition, P15 reported that there was no specialized team to take on severe cases and she was the only MHP working with 'young people going through severe mental health problems' (R1). P15 concluded by expressing that 'if there were more professionals working on the

same file or with whom she could share her work with, it would take away some of the pressure' (R5).

Organizational Community

Organizational community captures the 'overall quality of social interaction at work' and it is an important area of work-life because people tend to perform better and do well when they feel socially supported by people they respect (Leiter & Maslach, 2004; P. 98).

Inadequate Social Support

Inadequate social support captures employees' experience or perception that they are *not* cared for, valued, or part of a social network of mutual assistance (Taylor, 2011). Four out of eight participants identified inadequate support as a demanding aspect of working in an interdisciplinary team that contributes to stress. Among these four participants, three belong to G1 and one to G2. Considered a somewhat prevalent theme because at least two participants from two groups discussed this topic.

G1 (experienced of burnout): All 3 participants from G1talked about inadequate social support when discussing demands associated with IDT.

P1 reported that in-depth interdisciplinary team meetings were replaced by intra-professional group meetings among CPs from the CIUSSS/CISSS. The interdisciplinary team meetings still took place, but P1 noted that they were shorter. P1 felt very positively about the in-depth meetings and stated that they 'were very important' because they would 'go deeper in either a theme, topic, or client' (R2). P1 also expressed a sense of loss and noted that she was 'nostalgic' about the time they used to have in-depth group supervision because they were a 'little team' and 'it worked so well' (R5). She could go to her team whenever she felt 'stuck or frustrated' (R3). In contrast, P1 expressed doubt about the intra-psychology group meeting and said that it was a big group, and they didn't know each other, which is why 'it took time' for them to 'get used to each other'. Indeed, the CPs from P1's LSN were 'still working on building an alliance as a group'. She felt that the reasons it took time were due to the group's size and the 'differences' in their 'approach' to treatment.

P10 also talked about in-depth ID group supervision and the mandatory group meetings among CPs, but her experience differed from that of P1. Specifically, she discussed the lack of support from her: interdisciplinary colleagues, professional groups, and the organization. P10 noted that 'today its very different' but 'a year and a half ago', the CPs supported the whole team at the interdisciplinary meetings but the 'support for CPs was not there' and 'it was too much' (R3). It should be noted that there is an organizational resource available to all employees, it's called the Employee Assistance Program, but P10 confessed that by the time she learned about it, it was too late for her; she was already depressed (R3).

P10 also discussed intra-professional group meetings among CPs, which she felt were 'unproductive' and 'not the best use of [their] time' (R8). The group did not discuss cases or issues concerning MH per se instead, these meetings were more like an information session, during which the CPs from her LSN reviewed topics like: "What are the services aligned to, what has the government made changes, what's coming, what you're going to need to be trained" (R8). In addition, P10 noted that there was no social support at these meetings because it was a large group and they didn't 'know each other', so it felt 'like in private'

practice (R7). P10 tried to organize meetings among CPs from her organization as an informal way to support each other, but it wasn't easy to find the time (R10).

Finally, P10 also discussed the lack of organizational support that offered 'professional help' specifically to CPs (R6). At the interview, P10 noted that if CPs wanted professional help from another psychologist, they had to 'pay for it out of pocket', which she did (R6). P10 felt that the lack of proper professional support for CPs was a vital resource because she brought it up later in the conversation when she noted that she was working with a CP and will continue to follow up with them afterwards (R6).

Like P10, P14 also identified a lack of social support and noted that the CPs supported the whole team, but it was very one-sided (R3). She commented on the perceived role of CPs and stated that 'there [was] something about being a psychologist that people under distress [would] come to' (R3). Specifically, P14 noted that when working in an interdisciplinary team, 'you [could] get a little sucked in' and get involved in supporting the stakeholders. Still, the colleagues did not reciprocate support necessarily. In fact, at times, P14 felt like she was the 'therapist of social workers' because but 'psychologists need[ed] help too', which was not always there (R3).

G2 (experienced some symptoms of burnout): Only P15 from G2 talked about inadequate social support when discussing demands associated with interdisciplinary teamwork. She reported 'feeling professional isolation' and at times' discouraged given the severity of cases' because there is no specialized team in her local service network. She is the only MHP working with young people going through severe mental health problems. Only 1 participant from G2 talked about inadequate social support when discussing demands associated with interdisciplinary teamwork.

Job Resources

All participants were asked to elaborate on three types of job resources that enabled them to work effectively in interdisciplinary teams. These included functional resources, resources that motivated CPs, and resources that contributed to their learning and professional development. Based on the participants' response analysis, I identified five themes that promote job engagement and capture the organizational predictors that reduce burnout. Table 4 (p. 24) lists the themes and identifies the participants that endorsed each theme.

Functional Resources

Functional resources are extrinsically motivating because they are 'instrumental in achieving work goals' (Schaufeli & Taris, 2014; P. 4). They foster the willingness among team members to put in the effort and, in doing so, achieve work goals and reduce the adverse effects of job demands on exhaustion. Human Resources, Planned Interdisciplinary Meetings, and Co-Location capture the functional resources that enable interdisciplinary teams to work effectively.

Human Resources (HR)

An organization has many kinds of assets, but human resources are its most significant assets (Indiparambil, J. J., 2019). This category of function resource consists of two types of human resources: Specialized HR and Administrative HR.

Specialized HR: Mental Health Professionals (MHPs)

Specialized HR includes social workers, clinical psychologists, psychiatrists, nurses, and GPs. Five out of eight participants identified mental health professionals as a functional resource that enabled them to work effectively in interdisciplinary teams. Among these five participants, two belong to the burned-out group and somewhat burned-out group, respectively, and the remaining one to the no-burnout group. Specialized HR is a prevalent theme because at least three participants (1 from each group) discussed this topic.

G1 (experienced burnout): Two out of three participants in G1 identified MHPs as a functional resource that enabled them to work effectively in interdisciplinary team.

P1 identified social workers as a specialized human resource and that even though they may not have the same academic background but they 'work[ed] similarly' and she got 'great input' from them when they collaborated to treat the same client.

P10 also echoed P1 comment about social workers and noted that CPs could 'learn a lot from social workers because they [would] go into the homes of the clients and observe[d] things such as family organization that CPs [did] not have access to. Plus, Social workers [were] also trained to know all other types of services and organizations that [were] available to help a young person' (R-13). In addition, P10 identified child psychiatrists from specialized services as a key functional resource that she consulted, especially in cases where she had 'tried several things' with the clients but there was 'no progress' and she was going 'around in circles' with them (R-14). Finally, P10 also included CP as a functional resource and noted that having more CPs on a team ensured that their caseload was manageable and that the complex cases were distributed (R-1).

G2 (experienced some symptoms of burnout): Two out of three participants in G2 also identified (social worker, psychiatrist, GP, nurse) as a functional resource that enabled them to work effectively in inter-disciplinary team.

P13 identified CPs and child psychiatrists from specialized services as functional resources and noted that she consulted them on cases that she wanted to refer to specialized services (R8).

P18 identified mental health professionals (including GP, respondent psychiatrists, social worker, and nurses) from her team as functional resources and noted that they helped her with 'navigating the healthcare system' (R2), and 'how it functions [i.e., how patients are referred and how they are looked after]' (R3).

G3 (no burnout): P20 from G3 also identified respondent psychiatrists as a functional resource and noted that she consulted them regularly during the monthly meetings (R2).

Administrative Human Resources

Administrative Human Resources include: clinical leader, service coordinator, and clinical operations advisor and clinical coordinator. Four out of eight participants identified administrative staff as a functional resource that enabled them to work effectively in interdisciplinary teams. Among these four participants, two belong to the burned-out group, and one to the somewhat burned-out and no burnout group, respectively. Administrative HR

is considered a prevalent theme because at least three participants (1 from each group) discussed this topic.

G1 (experienced burnout): Two out of three participants in G1 identified administrative staff (clinical leader, service coordinator/navigator) as a functional resource that enabled them to work effectively in inter-disciplinary team.

P10 noted that 'CPs [could] always ask for a meeting with their clinical leader [chef clinicien] in order to talk about a problem, they [were] facing and get answer to a question' (R-3).

P14 identified service coordinator (coordinatrice de service) as a functional resource and noted that service coordinator (coordinatrice de service) 'help[ed] with providing information, solving problems, and connecting CPs with different partners. They … sign[ed off a case and therefore [had] an idea [about] the file. They [were] also a little higher up in the hierarchy and [had] the power to resolve conflict. In this way, they provide[d] real support and … supervision' (R-2). Building on the available administrative resources, P-14 noted that the clinical coordinator (coordinatrice clinique) addressed 'issues at the institutional level and supported CPs in solving problems between institutions'. In this way, clinical coordinators supported CPs if there was a conflict at the institutional level (R-3).

G2 (experienced some symptoms of burnout): P18 was the only participant in G2 that identified administrative staff as a functional resource that enabled them to work effectively in inter-disciplinary team.

P18 also identified Clinical Operations Advisor (conseillère en activités cliniques) 'respond[ed] to enquiries from CPs, coordinate[d] inter-institutional transfers, organize[d] meetings with professionals from other institutions, facilitate[d] consensus on the treatment objectives and develop[ed] an intervention plan' (R-6). Note that P14 referred to this position as a 'clinical coordinator'

G3 (no burnout): P8 was also the only participant in the no burnout group that identified administrative staff as a functional resource that enabled them to work effectively in inter-disciplinary team.

Specifically, P8 also identified **clinical coordinator** (coordonnatrice clinique) she acted as a 'mediator between the health professionals and service-users; and [took] the time during [the] planned meetings to build trust' (R-1). She also acted as an 'information officer rallying health professionals around service-users' family' (R-1). P8 was also in a 'supervision role and facilitate[d] clinical meetings with MHPs [psychologists, social-workers, and psycho-educators] to discuss cases and guide certain situations' (R-2).

Planned Interdisciplinary Meetings

A planned interdisciplinary meeting is a special category of meeting that has a stated objective, is systematic, structures, and managed by a leader, usually a GP (Lopez-Fresno & Savolainen, 2014). Six out of eight participants identified formalized interdisciplinary consultations as a functional resource that enabled them to work effectively in interdisciplinary teams. Among these six participants, three belong to the burned-out group, two to the somewhat burned-out, and one to no burnout group respectively. Planned Inter-

disciplinary Meeting was a prevalent theme because at least three participants (1 from each group) discussed this topic.

G1 (experienced burnout): All three participants in G1 identified formalized interdisciplinary consultations as a functional resource that enabled them to work effectively in an inter-disciplinary team.

P1 talked about consultations with the interdisciplinary professionals (psychotherapists, social workers) within her Adult MH team as a resource. She noted that her 'team [had] regular meetings once a week and she consult[ed] a lot with other MHPs on her team' (R3, -5). And when P1 worked with a 'client that [was] suffering from addiction, the occupational therapist work[ed] with the client on their skills to go back to work, while [she] work[ed] on anxiety or depression' (R5).

Similarly, P10 explained that her team would 'set up a consultation meeting to work together on a treatment plan' when she started a new case (R9). Additionally, she talked about two other types of planned consultations, including primary care meetings and consultation with specialized services. P10 elaborated that her LSN recently instituted primary care meeting[s], which [were] also 'something new' (R3). There were 'psychologists, social workers, nurses, and nurse navigators at these meetings that [were] there to hear cases from social workers or specialized educators to support them; so it [was] more structured' (R3). She also identified interdisciplinary consultation with specialized services ('la rencontre de deuxième niveau') as another resource (R11). At these meetings, 'a child psychiatrist and a psychologist from specialized services [heard] the cases to evaluate whether these cases should be referred to child psychiatry or there [were] other things that can be done to avoid overburdening the hospital' (R12). P10 explained, 'in addition to other cases, there are a lot of child psychiatry cases. [We did this to] avoid bottlenecks and [to ensure] that we did everything before deciding …[to] refer a case to child psychiatry' (R12).

Finally, P14 noted that even though 'Douglas hospital [was] not associated with her CIUSSS, her team worked with the child psychiatry unit because it [was] physically closer to Verdun than the Sainte-Justine hospital. The child psychiatry [from specialized services] would come and present the cases that they wanted to send over [and our] team could also go there' (R4).

G2 (experienced some symptoms of burnout): Two out of three participants in G2 identified formalized interdisciplinary consultations as a functional resource that enabled them to work effectively in inter-disciplinary team.

Like P10 & P14, P13 also identified interdisciplinary consultations with specialized services as a functional resource and noted that 'there [was] a mechanism that link[ed] primary-care and specialized services' (R8), and through this mechanism, her team could present the files that they wanted to refer to specialized services.

P18 also identified formalized interdisciplinary consultations as a functional resource and noted that her adult MH team had an 'interdisciplinary meeting once a month, and there [was] a responding psychiatrist present at this meeting that [could] refer people to psychiatry or provide[d] medication information' (R1). A GP also attend[ed] this meeting and help[ed] with explaining not only pharmacological aspects but also the functioning of the health system (R1). P18 confided that CPs felt somewhat 'helpless' when it [came] to how the

health-system function[ed] because it [was] not their area of expertise (R1). She also noted that working in an IDT was helpful, but they didn't have much time to discuss issues. They met once a month, and several people presented cases (R5).

G3 (no burnout): Only 1 participant in G3 identified formalized interdisciplinary consultations as a functional resource that enabled them to work effectively in inter-disciplinary team**.**

Like participants from the other two groups, P20 also identified 'monthly consults with a psychiatrist [as] a good functional resource' (R2). She also explained that during these meetings, if she [was] working with someone that [were] not physically present in her workplace, she [could] reach them easily by email or telephone (R2).

Co-Location

Co-location means that professionals in a team - and their close collaborators - work, either within the same organization or in-close proximity. Three out of eight participants identified co-location as a functional resource that facilitated interdisciplinary teamwork. This theme is considered a prevalent theme because three participants from three different groups discussed this topic.

G1 (experienced burnout): P14 from G1 reported that the specialized services team from the child psychiatry unit at the Douglas hospital would present the cases they wanted to send over in person. They were able to do this because the Douglas hospital was in the same neighbourhood as CLSC Verdun. P14 found this practice to be 'very motivating' because it created opportunities for the two teams to get to know each other and cultivate a personal connection.

G2 (experienced some symptoms of burnout): P13 from G2 explained, 'when you share[d] the same workspace such as CLSC; you get to know each other, which [made] it easier to talk' and connect with colleagues on different teams (R4).

G3 (no burnout): Like P13 & P14, P20 from G3 said that it was convenient that her team worked at the same location. And 'the people' on her team and 'their offices' were close to hers, which meant that she could easily discuss their common files (R4). Plus, P20 had access to her colleagues' notes and reports, which was also helpful (R4).

Motivation

Social support satisfies the basic human need of relatedness, and is therefore intrinsically motivating (Schaufeli & Taris, 2014).

Social support

Social support captures employees' perceptions or experiences that they are cared for, valued, or part of a social network of mutual assistance (Taylor, 2011). This theme is the most prevalent theme because all eight participants identified social support from their interdisciplinary colleagues as a source of motivation.

G1 (experienced burnout): All three participants in G1identified social support as a source of motivation.

P1 identified social support from her colleagues to be a source of motivation and noted that she had been advocating for interdisciplinary teamwork for a long time at work (R6). P1 'loved' working with her team (R7). She called her colleagues 'incredible and wonderful' and noted that she would go to them, whenever she felt 'stuck, frustrated, or wasn't sure how to proceed' (R8). But P1 wasn't all Pollyanna because she also pointed out that her colleagues didn't always agree but worked through disagreements with 'respect', which was a 'big plus' for her (R9).

P10 also identified the social support she received from her interdisciplinary colleagues as a source of motivation and noted that it was one of the reasons why she preferred 'working in the public healthcare system instead of private' (R8). Specifically, she stated that having more than one professional meant 'more resources to help clients' and opportunities for the team to 'help' and 'support' each other (R14).

P14 also identified social support as one of the motivational resources and noted that she 'loved working with a psycho-educator' because they 'got along' and 'worked well together' (R7). P14 felt 'supported' when they collaborated on difficult cases, and it was especially motivating when these files moved forward (R7). They were 'part of a team working together to help a young person' (R7). P14 shared that the social support aspect of interdisciplinary work was 'very helpful' and she 'miss[ed]' it in her private practice (R7).

G2 (experienced some symptoms of burnout): All three participants in G2 identified social support from their interdisciplinary colleagues as a source of motivation.

P13 identified social support in interdisciplinary work to be motivating and noted that each profession had a 'complementary approach' (R5). For example, if she was 'doing psychotherapy with a client', and there was a social worker who was helping them take care of things at home because the family needed more support, then 'of course that [was] motivating because it was effective in helping a client' (R5). In addition, P13 felt emotionally supported and 'less alone' especially when she was 'working with clients that were severely ill or were difficult' (R6).

P15 also identified social support to be motivating and noted that interdisciplinary work created opportunities to work collaboratively towards a shared goal (R1). She also noted that they shared difficult and challenging experiences, which was not only 'empowering and encouraging' about also 'normalized how they felt about a patient or a problem' (R1).

P18 also identified social support as a motivational resource and noted that working in an interdisciplinary team was helpful because each professional had an 'expertise' that was 'completely different' (R8). She also added that interdisciplinary collaboration created conditions for colleagues to support each other and benefit from the diversity of perspectives, including tools to help clients (R8).

G3 (no burnout): Both participants in G3 identified social support as a source of motivation.

P8 identified social support as one of the motivational aspects of working in an interdisciplinary team but noted that there was 'a lot of pressure' as well (R4). Specifically, she noted that it was 'very challenging' but found the support in working collaboratively to

be very 'motivating and stimulating', especially because this way of working was relatively new in primary mental healthcare, and they had made 'great progress' in terms of working collectively in a network.

Like P13 & P18, P20 also identified social support as one of the motivational aspects of working in an interdisciplinary team especially in youth mental health. Specifically, she noted that she 'loved working as a team' and having more than one person working on a file meant that not only the 'journey to recovery was faster' but she could also share her 'impressions of the family' with her colleagues and get their assessment (R5). For example, P20 explained that she couldn't be 'the therapist of the family, teenager, and parents' (R5). For this reason, she would often ask for help from social workers and social workers 'provided a space for parents [and] to help them along the way as well' (R5). This way, she saw the young person, and when it was relevant, 'they had family meetings' (R5). P18 also noted that she 'did not feel alone when managing very complex files' and that had a very positive effect as well (R5).

Learning & Professinal Development

Knowledge Exchange captures the aspect of working in interdisciplinary teams that stimulated learning and professional development among CPs.

Knowledge Exchange

Knowledge-exchange captures the ideas, evidence or expertise shared through such interprofessional communication (Herschel, Nemati, & Steiger, 2001). All eight participants identified knowledge gained through clinical and interpersonal interactions as a resource that contributed to their learning and professional development. This theme is considered a prevalent theme because all eight participants identified knowledge exchange as as a source of learning and professional development.

G1 (experienced burnout): All three participants in G1identified knowledge gained through clinical and interpersonal interactions as a resource that stimulated learning and contributed to their professional development.

P1 identified clinical exchanges with her interdisciplinary colleagues as a resource that contributed to their learning and noted that 'there [was] an element of personal and professional growth that [came] with working in an interdisciplinary team because there [were] different perspectives and you [got] more rich information about a client' (R15). P1 also noted that these exchanges created opportunities to observe and learn from other professionals in her team and integrate relevant concepts into her own practice (R11). For example, P1 would observe the 'occupational therapist, while [they] worked with a client' and learned about recovery aspects, such as: 'how [did they] decide that a client [was] ready to go back to work?' (R12). P1 had similar interactions with 'social workers and nurses' (R13), including doctors and psychiatrists from whom she learned about 'medication, body, and mind' (R14).

P10 also identified clinical exchanges with interdisciplinary colleagues as a resource that contributed to their learning and professional development. For example, she noted that she 'learned a lot from social workers because they [went] into the field [and] into the homes [of clients]. They [told] us things that they [saw], including family organization' (R13). In addition, P10 pointed out that the social workers were trained to know about other types of

resources (such as: community and intersectoral organizations), which she could use to redirect a young person (R13).

P14 also identified clinical exchanges as a resource that contributed to their learning and professional development and noted that 'working in an interdisciplinary team contributed to [her] learning and professional development through interactions with colleagues during monthly supervision and meetings with child-psychiatrist (R8). She also noted that 'often CPs [were] so overloaded with work that they [didn't] have the time to take advantage of other learning opportunities that were available outside of structured interactions with colleagues' (R8).

G2 (experienced some symptoms of burnout): All three participants in G2 identified knowledge gained through clinical and interpersonal interactions as resource that contributed to their learning and professional development.

P13 also identified clinical exchanges with colleagues as a motivational resource and noted that 'working in an interdisciplinary team [had] an impact on [our] learning. For example, [we] learn[ed] from each other during meetings when [we] discuss[ed] what other health-professionals [had] done [to help a client]' (R7).

P15 also identified clinical and interpersonal exchanges with colleagues as a resource that contributed to their learning and professional development and noted that working in an interdisciplinary team contributes to professional development in several ways. For example, when she 'work[ed] with a nutritionist on an eating disorder - who [knew] different aspects of nutrition and eating disorders' (R2), the clinical exchange with the nutritionist would give her ideas on what to look for or encouraged her to do readings and learn more (R2). MHPs in the team did the work individually but professional exchanges with different people (or people with different ways of doing things) sparked the desire to seek out and learn more (R2). Finally, P15 also noted that 'it [was] about respect and there [was] personal growth when [we] adapt[ed] to each other and work[ed] together despite perceived conflicts or aspects that differentiate[d] us' (R2).

P18 identified knowledge exchanges with colleagues as a resource that contributed to her learning and professional development and noted that working in an interdisciplinary team helped her expand her knowledge of the healthcare system and improved her skills. Specifically, P18 noted that there was a lack of information between primary care and specialized services that psychologists did not have access to. Consequently, she felt 'helpless' but interactions with her colleagues (doctors and psychiatrists) helped to bridge this gap (R9). P18 also noted that having access to this diversity of experiences helped her with understanding 'how programs [such as social assistance] work[ed]' and gaining 'a systems perspective' on how health services were organized (R9). These exchanges allowed CPs to offer a better service to clients because they themselves understood 'the other side of the coin' and could better explain to clients 'why' things worked the way they did (R9).

G3 (no burnout): All participants in G3 identified knowledge gained through clinical and interpersonal interactions as resource that contributed to their learning and professional development.

P8 identified clinical exchanges with colleagues as a resource that contributed to their learning and professional development and found the working in 'interdisciplinary team to

be very enriching' (R3). Specifically, P8 noted that 'when you [worked] alone on a file, there [was] a possibility that you [could] ignore other opportunities and get limited in your understanding in terms of what [could] be offer[ed]' (R3). P8 felt that 'a diversity of perspectives (including, other therapist, nurses, and child psychiatrists) supplement[ed] our own understanding or (alternatively) inform[ed] our actions and guide[d] services' (R3).

P20 also identified clinical exchanges as a resource that contributed to their learning and professional development and noted that interdisciplinary teamwork contributes to professional development because it creates opportunities to learn from a diversity of perspectives and see how other professional's work. For example, P20 reported that she had 'colleagues that [had]specific expertise' and when she was working on a file that related to that expertise, she would go and 'consult them' (R6). And during these consultations, her colleagues showed her a way of seeing things that she had not considered before (R6). In this way, P20 learned about different topics that helped her in her professional practice and in developing her skills as a psychologist (R6).

Discussion

This chapter presents my interpretation of the six job demands and five job resources associated with interdisciplinary teamwork in primary care. My goal is to provide evidence that adequately substantiates each themes' prevalence or keyness, tells the complex story of the data that demonstrates the rigour and quality of the analysis and make a compelling argument for why the six themes are significant organizational predictors of burnout.

But first, why are interdisciplinary teams an exciting area of inquiry and what is involved in interdisciplinary teamwork? Working in an interdisciplinary team is complex because many different factors - at the individual, team, and organizational level - influence team processes and ultimately outcomes. Therefore, I will begin this chapter with a brief description of the interdisciplinary team activities and introduce key concepts to provide readers with a reference frame. The primary team process associated with interdisciplinary teamwork is collaboration. To collaborate is to work together towards organizing job tasks to achieve mutually agreed-upon work goals. And so, mental health professionals (MHPs) collaboratively convert inputs to clinical outcomes through cognitive, verbal, and behavioural activities (adapted from Mark, Mathieu & Zaccaro, 2001; P. 357). In the context of this thesis, the inputs include functional resources, such as planned meetings and professional expertise. And the main activity involves interprofessional communication characterized by two features: clinical exchange and collaborative exchange. Clinical exchange is 'objective and dependent upon clinical information, clinical skills, and standardized tools and procedures'. In contrast, a collaborative exchange is 'less formal and relies on dialogue, cross-disciplinary knowledge and role identity' (Aase, Aase, Dieckmann, Bjørshol, & Hansen, 2016; P. 91). In this way, planned interdisciplinary meetings are an organizational tool that pools professional expertise and creates collaboration and knowledge exchange opportunities.

Job Demands

The CPs in the sample identified six themes capturing job demands that clustered around the three areas of work-life and contributed to their stress experience, including the *Organizational Aspects of Interdisciplinary Teamwork, Role Creep, Organization's Internal Environment, Increase in Job-Tasks, Inadequate Human-Resources (HR), Inadequate Support*. The third theme (*Organization's Internal Environment*) encompassed two sub-themes (*Physical Environment and Organizational Climate*). I organized the themes around the three areas of work-life proposed by Leiter and Maslach (2004): Workload, Control, and Community. The Table 3 (p. 23) shows that the CPs in G1 (experienced-burnout) were impacted by six themes under the three areas of work-life, including control, workload, and organizational community. Meanwhile, the CPs G2 (experienced some symptoms of burnout) experienced a lack of control in only one aspect of work-life. Still, they were impacted by all the themes linked to workload and organizational community. Finally, CP in G3 (experienced no burnout) experienced a lack of control in the organizational aspect of interdisciplinary teamwork and increased job tasks contributing to her workload. To facilitate the discussion, I have included a is a visual representation of the relationship among the three areas of work-life (Figure 8; p. 50).

Control Problems

According to Leiter and Maslach (2003; P. 96), 'control problems occur when workers have insufficient authority over their work or [cannot] shape the work environment to be consistent with their values.' Employees are unlikely to feel a sense of efficacy if they cannot influence decisions that affect their work. And given the central role control plays in employees' ability to influence coworkers and work processes, control problems also impact other areas of work-life, including workload and organizational community (i.e., issues of mutual support) (Leiter & Maslach, 2004). Against this background, I will present why the control problems associated with organizational aspects of interdisciplinary teamwork, role creep, and the organization's internal environment are important predictors of burnout among CP working interdisciplinary teams in primary care.

Control Problem: Organizational Aspects of Interdisciplinary Teamwork

This theme captured the CPs' perceived lack of control over key inputs, i.e., the organization of planned interdisciplinary meetings and access to professional resources. It is a prevalent theme because at least three participants (1 from each group) discussed this topic. More precisely, six out of eight participants identified this theme as one of the demanding aspects that contributed to their stress (2 belong to G1, 3 to G2, and 1 to G3). To evaluate the impact of this theme across groups, I conducted two pairwise comparisons between G1-G2 and G2 -G3. As expected, the analysis revealed that as the level of burnout decreased from G1 to G3, the control problems linked to this theme also reduced.

First, the comparison between G1-G2 showed that both groups expressed a lack of control over functional resources (in-puts) that facilitated knowledge exchange. G1 expressed a lack of control over the organization of planned meetings. For example, the CPs in this group talked about the intra-professional meetings and expressed a lack of control over these meetings' scope. Given that planned meetings are an important knowledge-sharing tool, P10 stated that she would have preferred to discuss 'cases or issues concerning mental health' at the intra-professional meetings (R8). Instead, these meetings were more like 'information sessions' about changes that would impact CPs (R8). The exclusion of group supervision was a 'missed opportunity' and a lacking resource (R8). Similarly, P1 talked about in-depth interdisciplinary meetings and noted that she too preferred to have 'in-depth clinical discussions', which she did at the in-depth interdisciplinary meetings (R2). But the management replaced them with those as mentioned above and, in doing so, took away that opportunity. Besides their inability to influence the scope of intra-professional meetings, G1 expressed their perceived lack of control over deciding the meeting location. They found the location of these meetings to be very 'inconvenient' because they were held 'off-site', which took time and energy (P1-R3; P10-R7). Plus, the intra-professional meetings were 'mandatory', and the participants felt that they had no choice but to 'travel', which was yet another thing that added to their workload (P1-R3). In sum, the intra-professional meeting was a physical job-demand that they didn't control and contributed to their workload.

In contrast to G1, which lacked control, G2 expressed inadequate access to professional expertise (i.e., MHPs). For most of the group, the main barrier was the team size that restricted their time to discuss clinical cases at the planned meetings with psychiatrists and general practitioners (GPs). P13 said there were a 'large number of professionals on the team'

and 'it was difficult to find a time to meet' due to scheduling conflict (R1). In one instance, it 'took three months to organize a meeting with other team professionals who were following the same patient' (R1). Likewise, P18 reported that there were 'twenty people' in her team and 'monthly meetings with the [general practitioner (GP)] and respondent psychiatrists [were] not enough to discuss cases; [because] several people [had] requests and they [were] unable to address them all' (R3). Inadequate time with GPs and respondent psychiatrists meant that there were insufficient resources. This shortage was a hindrance and a stressful organizational demand that prevented CPs from collaborating effectively. But overall, G2 experienced more control over the resources than G1. Additionally, the inadequate access didn't add to their workload.

The second pair-wise comparison between G2-G3, showed that both groups lacked access to MHPs. Like P13 and P18 from G2, P20 from G3 reported her team met with psychiatrist once a month and given the 'size team', there was 'no time' to discuss cases at these meetings. She could not book an appointment with the psychiatrist to 'discuss the issues they had in common' because they had no time in their schedule to discuss cases outside the monthly meetings (R-10, -11). However, P15 from G2, reported that it was 'rare' that she 'work[ed] with another mental health professional' (R2). The 'biggest challenge' was that there was 'no interdisciplinary work', which she viewed as a loss (R2). Taken together, G3 had more control over access to professional resources when compared to G2 on the whole. Consequently, the feeling of helplessness in G3 was likely less severe than G2.

Based on the analysis, I concluded that the control problem linked to the organizational aspects of IDTW is a prevalent job demand encountered by CPs in primary care that contributed to the stress and feelings of helplessness experienced by participants. The group that experienced this job-demand most intensely also experienced burnout, suggests that it is an important organizational correlate of burnout.

Control Problem: Role Creep

Role-creep happens when employees perform tasks outside of their role or agreed upon scope of their job. Interestingly and unsurprisingly, all three participants in the burned-out group identified control problems linked to role creep as one of the demanding aspects of working in an interdisciplinary team. To evaluate the impact of this theme on participants within this group, I reviewed the types of tasks that expanded their scope of responsibilities. For example, P1 reported that she was asked to 'run psycho-education groups', which she felt under-utilized her skills, but she did it willingly (R7). She thought that this task was outside her role because technicians could run them; 'you don't need professionals' (R7). Similarly, P10 was asked to work with her office' door open' to 'support social workers and specialized educators' (R-3). In addition to her regular caseload and mandatory administrative tasks, this extra responsibility was 'too much' and became 'very heavy' (R3). Finally, P14 expressed the role of a CP in a public system is somewhere between a clinician and a liaison officer. Still, the reform led them too far in the direction of a liaison officer (R-1). She felt as though, in addition to her client, she was the 'therapist of social workers and parents', when she worked in an interdisciplinary team-setting within a community based-practice (R-3). P14 concluded 'the boundaries around the role of psychologists [were] blurred' (R3) but with 'better-defined roles between partners [she] would have felt less overwhelmed and have more perspective' (R3).

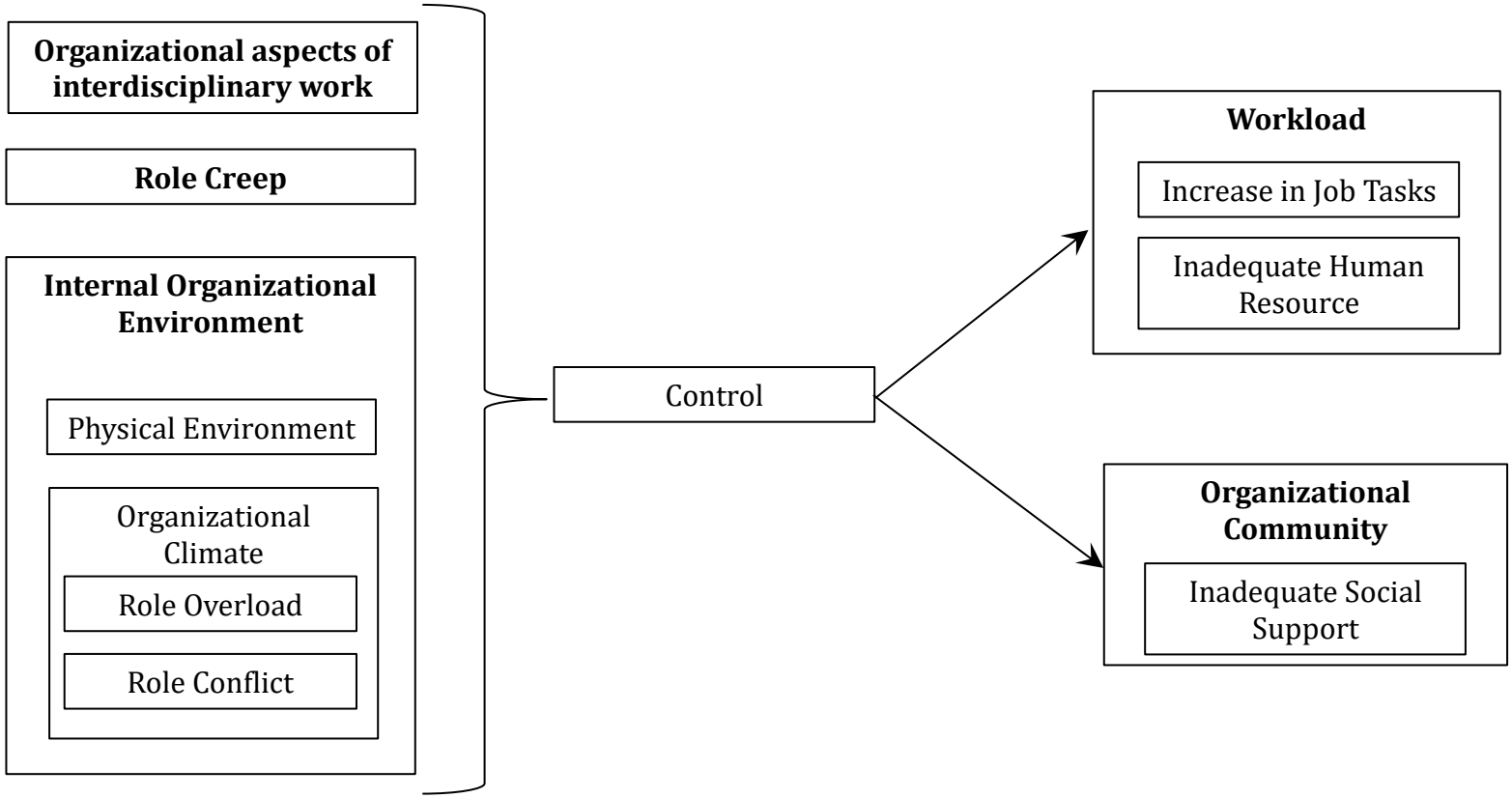


Figure 8: Areas of work-life and themes linked to interdisciplinary team demands

Based on the analysis, I concluded that CPs were asked to perform a combination of (routine and non-routine) cognitively and emotionally demanding tasks. These tasks increased the workload of CPs in G1, and their perceived lack of control over this role creep makes this non-prevalent theme a key one because it contributed to the stress and feelings of inefficacy experienced by them. The group that reported a lack of control over role-creep also experienced burnout, which suggests that it is an important organizational correlate of burnout

Control Problem: Organization's Internal Environment

An organization's internal environment is the 'totality of the present organizational state' (Gavin & Howe, 1978; P. 229). It includes 'physical environment' and is 'synonymous with organizational climate'. In this thesis, I have conceptualized the organization's internal environment as its physical environment and organizational climate.

Physical Environment: An organization's physical environment includes all material objects and arrangements of those objects, for example, furnishings, office plans, and ambient conditions such as lighting (Elsbach & Pratt, 2007). Physical attributes of spaces such as counselling rooms are essential in psychotherapy because they impact clients' perceptions of psychological safety, intimacy, and willingness to self-disclose (Davies, 2018). It is equally necessary for clinicians to feel a sense of agency in these spaces and minimize feelings of otherness, alienation, and stigma to build therapeutic rapport with their clients. Given the significance of this domain, I reviewed P14's comments on the topic, who was the only participant that talked about her workspace. She described it as 'small, cold and without any windows' (R7). The counselling rooms were 'not very conducive to therapy,' and she had to 'share [them] with other psychologists'(R6,7). It didn't make her 'feel valued' (R-7). Based on my evaluation of the excerpt, I included this non-prevalent theme because P14's perceived inability to shape her physical workspace to match the users' needs likely played a key role her subsequent burnout. Withdrawal behaviour due to lack of resources was probably a contributor as well. For these reasons, in the context of this study, physical environment is a relevant organizational predictor of burnout.

Organizational Climate: Organizational climate is a multidimensional construct referring to the shared meaning attached to an organization's policies, practices, and measures associated with the employee experience (Schneider, Ehrhart, & Macey, 2013). There are many conceptualizations of organizational climate in the literature, but following Green and colleagues (2014), I define it as a multidimensional construct encompassing role overload and role conflict.

Role Overload. High levels of role overload characterize a workplace where employees feel overwhelmed with work (Glisson et al., 2008), and it is an indicator of a stressful organizational climate. This dimension captured an important aspect of the organizational culture, i.e., a shared lived experience among the employees. This shared reality of feeling overwhelmed reflects and offers meaningful insight into the organization's policies and practices contributing to burnout. Given the relevance of this domain, I reviewed P14's comments on this topic, who was the only participant that talked about role overload. She shared '[we were] all overwhelmed with work' because 'the problem was bigger than [just] inadequate human resources' (R8, R10). Everyone had 'a lot of files,' and her colleagues dealt with the same 'overflow' of work (R8, R10). '[T]hey were [all] caught up in a hellish

performance cycle … no one stopped' (R-8). It was difficult to stay sane given the pressures. P14 concluded by evoking a provocative image 'even though there was excessive work', it was in a 'compassionate environment,' but there was 'something rotten underneath'. Based on my evaluation of the excerpt, I included this non-prevalent theme because P14's feelings of inefficacy to change the stressful organizational climate at work likely played a key role in her subsequent burnout. Exhaustion due to work overload was probably a factor as well. For these reasons, role overload is an important organizational correlate of burnout.

Role Conflict. High levels of role conflict characterize a work environment in which 'worker's preferred role is out of sync with important job qualities' (Leiter & Maslach, 2004; P. 97). Role conflict is another aspect of organizational culture that was reported by P14 only, but it succinctly juxtaposed the unique challenges that novice CPs experience against the demands of community-based practice, which is 'deeply rooted in the daily life' (R-5). She explained 'the work of a psychologist [is] very intimate. It require[s] a protected space – like a bubble – in which a patient [was] protected from the tornado of everyday life. This protected space allow[s] the patient to take distance from everyday life and figure out what they [were] going through so that they [could] fix it' (R-2). '[But] if you [yourself] caught in a tornado … [and] getting hit by [it] all the time' then as a clinician, it became difficult for her to help a client (R2). The interdisciplinary work kept her 'closer to the floor' and 'hurt the therapeutic bubble' that P14 attempted to build with the client (R5). She concluded there are 'psychologists that [are] very comfortable with the community-based approach'; but, as a novice psychologist, P14 found it to be 'very difficult' and 'hard to balance [it] against the work that a psychologist [did] in a more therapeutic space' (R-5). Based on my evaluation, I included this non-prevalent theme because P14's inability to meet the demands of community-based interdisciplinary practice and the subsequent feelings of inadequacy likely contributed significantly to her stress and burnout. I qualified role conflict as an important organizational correlate of burnout for these reasons.

Workload

The workload is the most fundamental aspect of work life. The relationship between workload and exhaustion is intuitive and straightforward. People experience work overload when they have "too much to do in too little time with too few resources" (Leiter & Maslach, 2004; P. 95). Also, recall control's central role in influencing co-workers and processes. This section will link the control problems (related to interdisciplinary teamwork and role-creep) and participants' workload.

Increase in Job-Tasks

Job-Tasks are actions carried out by workers in turning inputs into outputs. This theme captures the increase in CP's workload linked to additional (physical and psychological) job-tasks associated with interdisciplinary teamwork. All participants from G1, P13 from G2, and P20 from G3 reported increased job tasks. To evaluate the impact of this theme on participants across the three groups, I reviewed the types of tasks they were asked to perform. For example, participants in the burned-out group (G1) reported increased job-tasks that were a combination of routine and non-routine tasks that were both cognitive and emotional. Specifically, P1 said, 'in the last 3 to 4 years there was a switch' in the governance, and the management began to institute 'more and more' mandatory tasks, which added to

their workload (R-4). She was asked to 'run psychoeducation groups' (R7) and attend 'inconvenient' mandatory intra-professional meetings; these two tasks were among the list of things they 'had to do [among] so many in the last three to four years' (R-3). Next, recall that P10 reported that she worked with her office door open to 'support social workers and specialized educators' (R3). Plus, she was 'asked to conduct evaluations for autism spectrum disorder' (R9). P10 saw the coordination and delivery of this new service as a challenge (rather than a hindrance), but she pointed out that it would 'add to the workload' (R-9). Finally, P14 talked about emotional labour and said that 'people under distress feel like they can come to a psychologist' (R-3). She also noted that 'there was a pressure to take on more workload' (R9). '[I]n addition to the work with clients,' P14 expressed 'there was an overflow of administrative tasks required by the CIUSSS,' and felt an implicit performance demand behind these tasks (R-9).

Next, P13 from the somewhat burned-out group (G2) discussed the increase in a routine job-task. Specifically, she talked about the task of developing a treatment plan when she took on a 'new case' (R5). P13 reported that this straight-forward task was a challenge because she was in a big team. And the planning and coordination involved in meeting with her colleagues to develop a treatment plan took more time due to scheduling conflict (R6). Finally, P20 from the no-burnout group (G3) reported increased job-task because she couldn't conveniently access the information, she needed to do her job effectively. P20 explained that she 'work[ed] with the department of psychiatry but didn't have access to their database'. Consequently, she had to physically go to the archives to access the psychiatrist's notes, and it was a waste of time because she couldn't bring the files back to her office (R9). This additional workload is the textbook example of a hindrance.

Based on the analysis, I concluded that the G1 experienced an increase in job-tasks that needed more effort, which contributed to their workload. Work overload leads to exhaustion, which in turn mediates the relationship between workload and cynicism and workload and inefficacy (Cordes & Dougherty, 1993; Lee & Ashforth, 1996; Schaufeli & Enzmann, 1998). Besides the expected relationship between the increase in workload and burnout, I also found that the tasks reported by the G1 were associated with the control problems linked to role creep and the organizational aspects of interdisciplinary teamwork. Accordingly, the additional analysis of G1's experiences revealed that the impact of control problems on employee burnout is layered and complex. First, the control problems impacted G1's sense of efficacy; second, they had a knock-on effect on their workload, which contributed to their exhaustion. In sum, I discovered that increase in job-tasks is a prevalent job demand encountered by CPs in primary care that contributed to stress and fatigue. Also, the group that experienced this job-demand most intensely had experienced control problems most intensely. This insight confirms that increased job-task is an important correlate of burnout and provides additional evidence demonstrating the significance of control problems.

Inadequate Human Resources

A human resource (HR) is one person within an organization's overall workforce. Collectively this group trades their talents, skills, and labour for compensation to help the organization succeed (Heathfield, 2021). The theme of inadequate HR captures the increase in CPs' workload because there aren't enough employees to meet its demands. Only participants from G1 and G2 discussed this topic, whereas no one from the G3 did. To evaluate

the impact of this theme across groups, I conducted a pairwise comparison between G1-G2 and reviewed the underlying causes that explained the lack of human resources. First, as expected, as burnout went down from G1 to G2, the number of participants that reported inadequate HR also decreased.

For example, two participants in G1 reported inadequate HR. P10 indicated that 'the management eliminated the nurse navigator's position' and 'the psychologist in charge went on maternity leave' (R-5,6). It left P10 and the other CP on her team to take on the workload of two employees, and that was how she became 'overloaded with work' (R-5,6). Similarly, P14 said there was a 'scarcity of psychologists in the CIUSSS', and the general attitude among health professionals was 'okay, we have a psychologist, let's make the most of them' (R-4). Plus, there were only eight CPs on her team, and they served the entire Centre-South territory of Montreal, which had a population of 299555. If there were more CPs, P14 said she would have felt 'less overwhelmed' (R-8).

In contrast, only P15 from G2 discussed inadequate HR. She was the 'only MHP on her team' with 'no social worker to work on other challenges that a young person may be going through' (R-1). There was such a 'shortage of professionals (i.e., occupational/speech therapist) that all the responsibilities fell on [her]' (R-4). In addition, there was no specialized team to take on severe cases, and she was the only MHP working with 'young people going through severe mental health problems' (R-1). P15 concluded, 'if more professionals were working on the same file or with whom she could share her work, it would remove some of the pressure' (R-5).

Based on the analysis, I concluded that inadequate HR is a somewhat prevalent job demand encountered by CPs in primary care that contributed to the workload, feeling of exhaustion, and withdrawal behaviour among the participants. The group that experienced high levels of this job demand also experienced burnout. Therefore, it is an important organizational correlate of burnout. In addition, the analysis also revealed the unique governance and planning challenges that the Ministry faces from a health human resource perspective. Quebec is a province with large land area and a large variation in population density across the health regions (Bayentin & colleagues, 2010). P15 (G2) worked in Abitibi-Témiscamingue with a population density of 2.5, whereas P10 and P14 (G1) worked in Chaudière-Appalaches and Montreal with a population density of 26.7 and 3769.1, respectively. The variation in population density offers nuance and shows that while both G1 and G2 experienced inadequate HR, the underlying factors informing the HR planning were different.

Organizational Community.

Organizational community captures the 'overall quality of social interaction at work'. It is an important area of work-life because people tend to perform better and do well when they feel socially supported by people they respect (Leiter & Maslach, 2004; P. 98). Lack of social support directly affects emotional exhaustion, depersonalization, and feeling of low personal accomplishments, all three burnout indicators (Jackson, Schwab, & Schuler, 1986; Prinset al., 2007). Once again, recall the control's central role in influencing co-workers and processes. This section will link the control problems (related to interdisciplinary teamwork and role-creep) and feelings of inadequate support.

Inadequate Social Support

Inadequate social support captures employees' experience or perception that they are not cared for, valued, or part of a social network of mutual assistance (Taylor, 2011). This theme captured the quality of social interactions at work, including losing support system, professional isolation, lack of reciprocity in support exchange). Only participants from G1 and G2 discussed this topic, whereas no one from the G3 did. To evaluate the impact of this theme across groups, I conducted a pairwise comparison between G1-G2; and reviewed the causes underlying perceived inadequate support and the effect on the organizational community. First, as expected, as burnout went down from G1 to G2, the number of participants who reported inadequate social support decreased.

For example, all three participants in the burned-out group discussed this topic. P1 had a support system that existed within her interdisciplinary team. And this mutual support exchange happened during the in-depth interdisciplinary meetings when P1's team would 'go deeper in either a theme, topic, or client' (R-2). However, she lost this positive connection with her team when the intra-professional group meetings among CPs replaced in-depth interdisciplinary team meetings. Her team still met, but they didn't go as deep as they used to. The loss of structure and time provided by the (planned) in-depth meetings led to a breakdown in P1's community. She used expressions like 'nostalgic', 'her little team', and 'it worked so well' (R5) to express her loss. P1 didn't get this support at the intra-professional meetings. She was unsure why but commented that maybe it was group 'size' and the 'differences' in their 'approach' to treatment (R-5).

Meanwhile, P10 reported a lack of support at all levels (interdisciplinary colleagues, professional group, and the organization). She explained that CP supported the whole team at the interdisciplinary meetings, but the 'support for [CPs] was not there' and 'it was too much' (R-3). The intra-professional group meetings among CPs were 'unproductive' and 'not the best use of [their] time' because they didn't discuss 'cases or issues concerning mental health' (R-8). Like P1, P10 also felt that it was a large group, and they didn't 'know each other', so it felt alone 'like in private' practice (R-7). She also tried to organize meetings among CPs from her organization as an informal way to support each other, but it wasn't easy to find the time (R-10). P10 also reported a lack of organizational support to pay for seeking 'professional help' from another psychologist (R-6). If CPs wanted professional help from another psychologist, they had to 'pay for it out of pocket', which she did (R-6). Additionally, P14 experienced a lack of reciprocity and noted that the CPs supported the whole team, but it was one-sided. Sometimes, when working in an interdisciplinary team, 'you [could] get a little sucked in' and get involved in supporting the stakeholders' (R3). Still, the colleagues did not reciprocate support necessarily. In fact, at times, P14 felt like she was the 'therapist of social workers' but 'psychologists need[ed] help too', which was not always there (R-3).

In contrast to G1, only one P15 from G2 discussed lack of social support and reported 'feeling professionally isolated' because she was the only mental health professional working with young people going through severe mental health problems. There were no mental health professionals or a specialized team for severe mental health disorders due to the low population density in the health region (see the analysis for Inadequate HR). Finally, no one from G3 reported inadequate social support.

Besides the expected relationship between burnout and inadequate social support, the analysis revealed that the underlying causes of insufficient social support were associated with control problems. P1 lost her support system due to her inability to control the organizational aspects of planned meetings. In P10 and P14 cases, the control problems linked to role creep forced emotional labour on them, which increased their workload and evoked feelings of resentment due to lack of reciprocity in the social exchange. Once again, the examination of G1's experiences revealed that the impact of control problems on employee burnout is also pervasive. In summary, inadequate social support is a somewhat prevalent job demand encountered by CPs in primary care that contributed to feelings of depersonalization and low personal accomplishments due to unmet basic human needs of relatedness. The group that experienced this job demand most strongly had also experienced control problems most intensely. This insight confirms that inadequate social support is an important correlate of burnout and provides yet another data point for the issues caused by lack of control.

Job Resources

The participants identified five themes, capturing the three categories of job resources, that reduce the demands associated with interdisciplinary work. that clustered around the three areas of work-life and contributed to their stress experience, including the *Organizational Aspects of Interdisciplinary Teamwork, Role Creep, Organization's Internal Environment, Increase in Job-Tasks, Inadequate Human-Resources (HR), Inadequate Support*. The third theme (*Organization's Internal Environment*) encompassed two sub-themes (*Physical Environment and Organizational Climate*). I organized the themes around the three areas of work-life proposed by Leiter and Maslach (2004):

Functional Resources

Functional resources are extrinsically motivating because they are 'instrumental in achieving work goals' (Schaufeli & Taris, 2014; P. 4). They foster the willingness among team-members to put in the effort and, in doing so, achieve work goals and reduce the adverse effects of job demands on exhaustion.

Human Resources (HR): An organization has many kinds of assets, but human resources are its most significant assets (Indiparambil, J. J., 2019). This category of function resource consists of two types of human resources: Specialized HR and Administrative HR.

Specialized HR include social workers, clinical psychologists, psychiatrists, nurses, and GPs. These MHPs are part of the CPs' interdisciplinary team in primary care, professionals from specialized services, and partner organizations. They work col-laboratively to achieve positive clinical outcomes for their patients. Two participants from G1 and G2 each, and one from G1 noted MHPs as a functional resource. To evaluate the perceived effectiveness of this resource on CPs' abilities to work effectively in interdisciplinary teams, I conducted two pair-wise comparisons between G1-G2 and G2-G3 and reviewed the MH professions mentioned by each group. I should note that before the analysis, I had expected an inverse relationship, meaning that as burnout went down, the number of MH professions reported would go up. However, the analysis revealed no apparent pattern. G2 identified four MH professions (social worker, psychiatrist, GP, and

nurse), followed by G1, which identified three occupations (social worker, psychiatrist, and CP), and finally, G3, which reported only psychiatrist.

Next, I looked for prevalence and found that all three groups had named psychiatrists and two identified social workers. The three groups said the following about psychiatrist:

- G1: '[they heard] our child psychiatry referral requests' (P10, R14);
- G2: 'consulted psychiatrists on [referral] to specialized services' (P13, R-8);
- G3: 'consulted them regularly during the monthly meetings' (P20, R2).

And, the two groups that named social workers said the following about them:

- G1 'got great input from them' (P1, R4); 'CPs could learn a lot from social workers because they go into the homes of the clients and observe[d] things such as a family organization that CPs [did] not have access to' (P10, R-13);
- G2: '[they are] helping [clients] take care of things at home… [that's] motivating because it is effective in helping the client' (P13, R5)

Based on the analysis, I concluded that psychiatrists were the most prevalent resource, followed by social workers. They were instrumental in achieving the work goals of interdisciplinary teams in primary care. Therefore, MHPs as a Specialized HR is an essential functional resource that mitigates the harmful effects of job demands in the team.

Admin HR provided many administrative duties to facilitate interdisciplinary clinical care and social support. Two participants from G1 and one from G2 and G3 identified Administrative HR as a functional resource. To evaluate the perceived effectiveness of this resource on CPs' abilities to work effectively in interdisciplinary teams, I reviewed the scope of job functions that this group provided to CPs in each group. The reason is that unlike MHPs in the specialized HR group that have established roles, Admin HR performs various tasks depending on the organization's needs. The analysis confirmed this possibility. Participants used titles like clinical coordinator, clinical operations advisor, clinical leader, and service coordinator to identify individuals in this role. However, they performed overlapping functions. Upon arriving at this realization, I looked for job functions that Admin HR performed on the whole. The bullets below provide a broad sampling of the functions they performed as reported by each group:

- G1: 'help[ed] with providing information … connecting CPs with different partners…sign[ed off a case … [had] an idea [about] the file….little higher up in the hierarchy [therefore had… power to resolve conflict….provide[d] real support ' (P14).
- G2: coordinate[d] inter-institutional transfers …facilitate[d] consensus on the treatment objectives … develop[ed] an intervention plan' (P18).
- G3: 'mediator between the health professionals and service-users … [took] the time during [the] planned meetings to build trust' … 'information officer rallying health professionals around service-users' family' … 'supervision role and facilitate[d] clinical meetings with MHPs … to discuss cases and guide certain situations' (P8).

Based on the analysis, I concluded that Admin HR is a prevalent resource that facilitated interdisciplinary collaboration and enabled CPs to achieve their work goals.

Therefore, they are an essential functional resource that mitigates the adverse effects of job demands in the team.

Planned Interdisciplinary Meeting is a special category of meeting that is systematic, structured, and managed by a leader (Lopez-Fresno & Savolainen, 2014). It has a stated objective and presupposes that the attendees can and should prepare for the planned meeting. All participants from G1, two from G2, and one from G3 identified planned meetings as a functional resource facilitating interdisciplinary teamwork. To evaluate the impact of this functional resource on CPs' ability to work effectively in interdisciplinary teams, I reviewed the types of meetings participants discussed.

From G1, P1 noted that her 'team [had] regular meetings once a week and she consult[ed] a lot with other MHPs on her team' (R3,-5). Similarly, P10 explained that her team would 'set up a consultation meeting to work together on a treatment plan' when she started a new case (R9). Additionally, she talked about two other types of planned consultations, including primary care meetings and consultation with specialized services. P10 elaborated that her LSN recently instituted primary care meeting[s], which [were] also 'something new' (R3). There were 'psychologists, social workers, nurses, and nurse navigators at these meetings that [were] there to hear cases from social workers or specialized educators to support them; so it [was] more structured' (R3). She also identified interdisciplinary consultation with specialized services (‘la rencontre de deuxième niveau’) as another resource (R11). At these meetings, 'a child psychiatrist and a psychologist from specialized services [heard] the cases to evaluate whether these cases should be referred to child psychiatry or there [were] other things that the team could do to avoid overburdening the hospital' (R12). P10 explained, 'in addition to other cases, there are a lot of child psychiatry cases. [We did this to] avoid bottlenecks and [to ensure] that we did everything before deciding ...[to] refer a case to child psychiatry' (R12). Finally, P14 noted that even though 'Douglas hospital [was] not associated with her CIUSSS, her team worked with the child psychiatry unit ... [and they] presented cases that they wanted to send over [and our] team could also go there' (R4).

From G2, P13 noted that 'there [was] a mechanism that link[ed] primary-care and specialized services' (R8), and through this mechanism, her team could present the files that they wanted to refer to specialized services. P18's adult MH team had an 'interdisciplinary meeting once a month, and there [was] a responding psychiatrist present at this meeting that [could] refer people to psychiatry or provide[d] medication information' (R1). A GP also attend[ed] this meeting and help[ed] with explaining not only pharmacological aspects but also the functioning of the health system (R1). P18 confided that CPs felt somewhat 'helpless' when it [came] to how the health-system function[ed] because it [was] not their area of expertise (R1). She also noted that working in an IDT was helpful, but they didn't have much time to discuss issues. They met once a month, and several people presented cases (R5).

Finally from G3, P20 also identified 'monthly consults with a psychiatrist [as] a good functional resource' (R2). She also explained that during these meetings, if she [was] working with someone that [were] not physically present in her workplace, she [could] reach them easily by email or telephone (R2).

Based on the analysis of data excerpts, I concluded that planned meeting is a prevalent resource and an organizational tool for accomplishing specific tasks. It pools together

professional expertise, creates opportunities to collaborate and exchange knowledge. Therefore, it is an essential organizational resource that is instrumental in achieving work goals and reducing job demands.

Co-location captures an environment where professionals in a team - and their close collaborators - work, either within the same organization or in-close proximity. Three out of eight participants identified co-location as a functional resource facilitating interdisciplinary teamwork. To evaluate the impact of this practical resource on CPs' ability to work effectively in interdisciplinary teams, I reviewed the scope of the proximity.

P14 from G1 reported that the specialized services team from the child psychiatry unit at the Douglas hospital would come and present the cases they wanted to send over in person. They could do this because the Douglas hospital was in the same neighbourhood as CLSC Verdun. P14 found this practice to be 'very motivating' because it created opportunities for the two teams to get to know each other and cultivate a personal connection. P13 from G2 said, 'when you share the same workspace such as CLSC; you get to know each other, which [made] it easier to talk' and connect with colleagues on different teams (R4). P20 from G3 said 'the people' on her team and 'their offices' were close to hers, which meant she could easily discuss their common files (R4). Plus, P20 had access to her colleagues' notes and reports, which was helpful (R4).

I determined that two of the three participants shared offices in the same building, whereas one shared the same neighbourhood. Either way, there was consensus across the three groups that co-location facilitated collaboration and improved team cohesion. However, one cannot presuppose that co-location automatically implies collaboration. Research has found that even though co-location is helpful, but it doesn't mean that people will automatically collaborate if they work nearby (Barsanti & Bonciani; 2019). Co-location is a prevalent theme that facilitates interdisciplinary collaboration by making it easier for the MHPs to meet. The ease of collaboration is instrumental in achieving work goals, and it has other positive externalities. For example, meeting conveniently makes it easier for colleagues to support each other and have knowledge exchanges that satisfy that basic human need for relatedness and competence. Based on this determination, co-location is an important functional resource that reduces the negative impact of job demands and fosters a positive work-related state of mind.

Motivation

Social Support captures employees' perceptions or experiences that they are part of a social network that helps each other. This theme is the most prevalent as all eight participants talked about social support. To evaluate the impact of this resource on CPs' motivation, I assessed the type of support that the participants discussed. The analysis revealed that the participants identified three types of social support (instrumental, emotional, informational) as a source of motivation.

P1 from G1 said she 'loved' working with her team (R-7) … she would go to them whenever she felt 'stuck, frustrated, or wasn't sure how to proceed' (R8). The team didn't always agree but worked through disagreements with 'respect', which was a 'big plus for her (P1, R9). P10 identified social support as one of the reasons why she preferred 'working in the public healthcare system instead of private' (R-8). Having more than one professional

meant 'more resources to help clients' and opportunities for the team to 'help' and 'support' each other (R14). P14 'loved working with a psycho-educator' because they 'got along' and 'worked well together' (R7). She felt 'supported' when they collaborated on complex cases, and it was incredibly motivating when those cases moved forward (R7). They were 'part of a team working together to help a young person' (R7). P14 shared that the social support aspect of interdisciplinary work was 'very helpful', and she 'miss[ed]' it in her private practice (R7).

Similarly, from G2, P13 noted each profession had a 'complementary approach' (R5). If she was 'doing psychotherapy with a client' and a social worker was helping them take care of things at home because the family needed more support, then 'of course that [was] motivating because it was effective in helping a client' (R5). P13 also felt emotionally supported and 'less alone', especially when 'working with severely ill clients or difficult [ones]' (R6). P15 said that her team shared complex and challenging experiences, which was not only 'empowering and encouraging' but also 'normalized how they felt about a patient or a problem' (R1). P18 explained that each professional had their 'expertise' that was 'completely different' (R8). The interdisciplinary collaboration created conditions for colleagues to support each other and benefit from the diversity of perspectives to help clients (R8).

Finally, P8 from G3 reported that working in interdisciplinary teams was relatively new in primary mental-health care (R4). It was 'very challenging,' and there was 'a lot of pressure'; but they had made 'great progress'. She found the support in working collaboratively to be very 'motivating and stimulating' (R4). P20 noted that she 'loved working as a team' and having more than one person working on a file meant that the 'journey to recovery was faster'. She could also share her 'impressions of the family' with her colleagues and get their professional evaluation (R5). P20 couldn't be 'the therapist of the family, teenager, and parents', so she would often ask the social workers on her team for help (R5). And social workers 'provided a space for parents [and] to help them along the way as well (R5). P20 'did not feel alone when managing very complex files', which had a very positive effect (R5).

Additionally, I concluded that social support is a prevalent resource that is intrinsically motivating because it satisfies the basic human need for relatedness. Therefore, social support is an important organizational resource that mitigates job demands' negative impact on exhaustion and fosters positive work-related state of mind.

Learning and Professional Development

Knowledge Exchange captures a two-way exchange of ideas, evidence or expertise shared through activities such as clinical and collaborative exchanges. This theme is considered most prevalent because all eight participants discussed this topic. To evaluate the impact of this resource on CPs' learning and professional development, I reviewed the activities discussed by each participant. Interestingly, the analysis revealed that everyone unanimously identified knowledge gained through clinical interactions with colleagues as a resource contributing to their learning and professional development.

For example, within G1, P1 shared 'there [was] an element of personal and professional growth that [came] with working in an interdisciplinary team because there [were] different

perspectives and you [got] more rich information about a client' (R15). Similarly, P10 pointed out that the social workers were trained to know about other types of resources (such as: community and intersectoral organizations), which she use[d] to redirect a young person (R13). P14 noted that 'working in an interdisciplinary team contributed to [her] learning and professional development through interactions with colleagues during monthly supervision and meetings with child-psychiatrist (R8). But she also added 'often CPs [were] so overloaded with work that they [didn't] have the time to take advantage of other learning opportunities that were available outside of structured interactions with colleagues' (R8).

P13 from G2 shared, 'working in an interdisciplinary team [had] an impact on [our] learning. For example, [we] learn[ed] from each other during meetings when [we] discuss[ed] what other health-professionals [had] done [to help a client]' (R7). Similarly, when P15 'work[ed] with a nutritionist on an eating disorder' (R2), the clinical exchange with the nutritionist would give her ideas on what to look for or encourage her to do readings and learn more (R2). The MHPs in the team did the work individually, but professional exchanges with different people … sparked the desire to seek out and learn more (R2). Additionally, 'it [was] about respect and there [was] personal growth when [we] adapt[ed] to each other and work[ed] together despite perceived conflicts or aspects that differentiate[d] us' (R2). P18 shared that psychologist often lacked the systems perspective on health services organization. Consequently, she felt 'helpless', but interactions with her colleagues (doctors and psychiatrists) helped to bridge this gap (R9). The diversity of experiences helped her with understanding 'how programs [such as social assistance] work[ed]' and gaining 'a systems perspective' on how health services were organized (R9). These exchanges allowed her to offer a better service to clients because she understood 'the other side of the coin' and could better explain to clients 'why' things worked the way they did (R9).

Finally, P8 from G3 said, 'when you [worked] alone on a file, there [was] a possibility that you [could] ignore other opportunities and get limited in your understanding in terms of what [could] be offer[ed]' (R3). '[A] diversity of perspectives (including, other therapist, nurses, and child psychiatrists) supplement[ed] our understanding or (alternatively) inform[ed] our actions and guide[d] services' (R3). P20 had similar experiences with 'colleagues that [had]specific expertise', and when she worked on a file related to that expertise, she would consult them' (R-6). During these consultations, her colleagues showed her a way of seeing things that she had not considered before (R6).

Based on the analysis, I concluded that knowledge exchange is a prevalent resource that is intrinsically motivating because it contributes to learning and professional development and satisfies the basic human need for competence. Therefore, knowledge-exchange is a crucial organizational resource that fosters a positive work-related state of mind that buffers CPs from the negative impact of job demands on exhaustion.

Recommendations

The insights gained from this study can be beneficial in reducing the stressors experienced by CPs working in an interdisciplinary team setting in primary care and ultimately improve the quality of mental health service delivery. For example, findings from the study demonstrated that CPs expressed (1) a lack of control over some organizational aspects of interdisciplinary work such as planned meetings; (2) inadequate provisions for clinical consultations and supervisions, especially with psychiatrists; (3) concerns about the administrative and reporting burden; (4) appreciation and value of interdisciplinary teamwork and associated positive externalities of interdisciplinary collaborations, including social support and knowledge exchange. Based on these findings, I would like to submit the following recommendations:

1. **Participative Decision-Making and Autonomy**: findings related to the control problem associated with the organizational aspects of interdisciplinary teamwork suggests including CPs in the decision-making process, especially in the scope and intended purpose of the planned meetings. I appreciate that it can be challenging from the organization's perspective to bring together a large group of professionals from different organizations with some working part-time and others full-time. In these instances, the reflex to adopt a top-down, one-size-fits-all approach is convenient. Still, it has negative externalities, especially when employees are coping with broader organizational changes and experiencing uncertainties. A simple solution could be to survey CPs to include them in the decision-making process. Another recommendation is to have multiple meetings with smaller groups that share similar organizational cultures and share the results up the hierarchy to make decisions.
2. **Adequate Time for Consultations**: another finding that emerged from the analysis is the inadequate access to psychiatrists for clinical consultations. Effective collaboration requires a proper time for all team-related tasks. Several CPs reported that monthly meetings are inadequate for in-depth clinical discussions or supervision. There appear to be two issues—team size and prioritizing referrals to specialized services. The emphasis on operations (i.e. workflow vis-a-vis referrals) is understandable given the capacity strains experienced by the MHPs in specialized services. However, deprioritizing clinical consultations at the primary-care level takes away a crucial functional resource that impacts the quality-of-service delivery and hinders MHPs from reaping the intrinsic benefits of interdisciplinary collaboration. When the ministry rolled out the 2005 MHR, it projected 3 hours per month per 50,000 inhabitants. Reviewing the initial reform projections considering 17 years of data on caseload is recommended so that CPs have adequate access to resources that enable them to do their jobs effectively. In addition, I recommend reducing the team size. When it comes to the group size, experts recommend small groups as the most useful for knowledge transfer (Hudcová, 2014). Smaller groups offer more opportunities for participants to share their experience best practices, can inspire each other by asking questions/ commenting on things and thus stimulate communication. The group is still manageable. Finally, I also recommend making provisions for individual supervision with psychiatrists.
3. **Administrative Burden**: CPs expressed concern over performance-related reporting burden, administrative work associated with interdisciplinary consultations, and the

reports they had to produce. It was interesting that when CPs discussed workload, no one mentioned caseload being too high. Instead, they pointed to the 'additional things' required to provide mental healthcare as a hindrance preventing them from the primary task. To address these issues, I recommend creating a task force with a mandate to take a holistic view of the job demands on CPs, identify non-therapy-related tasks, determine the added value, and make recommendations to simplify and minimize the administrative burden.

4. **Digital Strategy**: linked to administrative burden are barriers to information sharing between organizations. CPs reported the inability to access databases from other organizations, which was another hindrance that prevented them from conveniently accessing the information they needed. Access to information is a long-standing problem in healthcare with valid concerns around privacy, confidentiality, and security. However, the creation of the Integrated Health and Social Service Centre following the 2015 Health System Reform has created a window of opportunity to overcome some of the historical barriers. To address this issue, I recommend leadership from senior management of integrated centres in developing a systems integration strategy that evaluates the current information sharing practices and IT capabilities of organizations within and across the integrated centres and is in the vanguard.
5. **Knowledge Creation**: One positive externality of interdisciplinary collaboration is knowledge exchange. The tacit and explicit knowledge exchange interaction during these collaborations is an untapped opportunity for innovation and developing new capabilities (Herschel, Nemati, & Steiger, 2001). I recommend creating a knowledge exchange protocol that takes tacit (collaborative) knowledge and codifies it into explicit knowledge so that professionals can conveniently recall and share the information in a structured manner.

Study Strengths and Limitations

This study's design and execution demonstrated several strengths. Qualitative research based on a direct-realist approach allowed me to provide the readers with a complete and rich picture of the job demands experienced by clinical psychologists (CPs) working in an interdisciplinary team context in primary care. The decision to identify themes at the sematic level ensured that the themes reflected the experiences of CPs honestly and without the filter of my interpretation.

The interview tool used to collect data is another strength of the study. The structure of the interview protocol, with discrete sections and strategic follow-up questions, complimented my approach to generate realist knowledge and captured various aspects of the job demands and types of job resources. This study is also unique in its approach to target and recruit a population that is not easy to access. A comprehensive recruitment strategy that leveraged Ordre des Psychologues du Quebec's policy on supporting research and social networks ensured that we could reach out to all registered clinical psychologists with a license to practice in Quebec.

The verifiability of the study's findings is another strength of the study. I took meticulous notes and documented steps throughout the data analysis process. The audit trail ensures that the organizational correlates of burnout are data-driven. Besides providing the replicability of findings, the process's transparency will also enable other researchers to carry out related research projects in the future.

Although the methodology had a series of strengths, limitations exist within this research. The primary disadvantage of a qualitative study is that it cannot be used to draw any definite causal inferences because it is not an experimental research design. For this reason, much of the study findings are exploratory and cannot be generalized. Furthermore, a direct-realist approach to thematic analysis assumes that the 'data more or less directly represent (mirror, reflect) reality' (Willig, 2012; p. 13). Consequently, I took the participants' accounts of the job demands and resources associated with interdisciplinary teamwork at face value. I avoided interpreting all non-verbal cues (such as tone and body language) and excluded all data that the participants did not directly and explicitly report. Moreover, I treated the participants' accounts as witness statements. I ignored the possibility that their recounting of the reality may have been distorted by poor memory recall or coloured by their agenda. Accordingly, this study is also handicapped by the disadvantages of the direct realist approach to conducting thematic analysis.

The gender of participants may also limit this research. The study participants were all women. This is in keeping with the known predominance of female psychologists in the clinical counselling field. Given the absence of male participants in the sample, I could not evaluate gender differences among participants. Research on gender differences has found gender differences, with women reporting higher levels of emotional exhaustion while men are reporting higher levels of depersonalization (Purvano & Muros, 2010).

Sample size and potential for self-selection bias are two other limitations of the study. The study had eight participants that were further divided into three groups, with only two participants in the group that did not experience burnout. Moreover, one of the two participants in this group was a licensed clinical psychologist working in an administrative

role as a clinical coordinator at the time of the interview. Consequently, I could not determine whether I had adequate to establish in each group. On the topic of self-selection, even though the CPs from across the province of Quebec had equal opportunity to receive the invitation to participate in the study, they decided entirely by themselves whether or not they wanted to participate. It may have resulted in participants that felt strongly about the topic self-selecting themselves to participate in the study. Therefore, their views may be over-represented.

Conclusion

Understanding the stressors encountered by mental health professionals in primary care is essential in ensuring their wellbeing. This study looked at the experiences of eight clinical psychologists working in interdisciplinary team settings and employed a direct-realist approach to thematic analysis.

The six themes resulting from the analysis captured the negatively valued job characteristics (i.e. demands). Interestingly, the six job demands clustered around three areas of work-life (Leiter & Maslach, 2004): control, workload, and organizational community. Among the six job demands, three were associated with control problems, two were linked to workload, and one to the organizational community. Specifically, the three job demands related to control problems include organizational aspects of interdisciplinary teamwork, role creep, and the organization's internal environment. The two demands associated with work overload encompass increased job tasks and inadequate HR. And finally, inadequate social support is associated with the organizational community. A group-wise comparison of the relevant (i.e. key) themes revealed that only the CPs that experienced burnout (G1) encountered role creep and a problematic internal environment.

In contrast, CPs that experienced some symptoms of burnout (G2) and no burnout (G3) did not report these job demands. Furthermore, among the prevalent themes, compared to G2 and G3, G1 experienced an increase in job tasks that required more effort, a lack of reciprocity in social exchanges, high levels of inadequate HR, and a total lack of control in relation to the organizational aspects of interdisciplinary teamwork. Taken together, I submit that the six job demands are the organizational correlates of burnout.

Moreover, a deeper analysis of the job demands revealed the complexity of interrelationships between areas of work-life and burnout. The CPs in the sample that experienced burnout also reported a lack of control, work overload, and inadequate social support. First, lack of control, work overload and inadequate social support (separately contributed to feelings of inefficacy, exhaustion, and withdrawal, respectively) resulting in greater burnout. But, given control's central role in influencing people and processes, problems with control also contributed to an increase in workload and damage community. Notably, this finding is in-line with Leiter and Maslach's (2004) mediation model, which the authors have put forth as a structured framework to investigate the organizational correlates of burnout.

Conversely, the data analysis on job resources identified three functional resources, i.e. human resources, planned interdisciplinary meetings and co-location. In addition, the participants also identified social support and knowledge exchange as job resources that motivated them and contributed to their professional development. Unlike job demands, a group-wise comparison of functional resources revealed that the three themes are prevalent but without any discernable pattern. Broadly speaking, this suggests a consensus among CPs that a given theme is a functional resource. Interestingly, all CPs unanimously endorsed social support and knowledge exchange as job resources that intrinsically motivated them and satisfied their basic human needs for relatedness and competence. Together, the five job resources reduce the negative effects of job demands that CPs encounter at work by enabling CPs to achieve their work goals and promoting a positive work-related state of mind.

The results from this study contribute to the literature on JD-R by validating previous findings. First, CPs' interpretation of lack of resources (such as social support and control) as job demands validates the JD-R's value-based conceptualization of demands and resources (Schaufeli & Taris, 2014). Second, the organizational correlates identified by CPs in this exploratory research also validate previous findings on the role of high workload, lack of control, and inadequate social support on burnout. Third, CPs' strong endorsement of job resources such as knowledge exchange and social support highlights the importance of motivational resources in buffering the adverse effects of job demands.

The findings from the study also expand our understanding of the interrelationships between categories of job demands and contribute to future research by generating hypotheses (e.g. do CPs with higher levels of control problems also experience more workload than those that do not?). In addition, it provides contextual data to develop valid instruments (i.e. constructs to evaluate job demands in interdisciplinary settings). Finally, this exploratory work lends empirical support for future research questions on JD-R (e.g. do workload and community variables mediate the relationship between control and burnout among CPs? What effects do urban versus rural settings have on the job characteristics of CPs in primary mental health teams? What effects do primary versus specialized team settings have on the job characteristics of CPs?).

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Appendix A-1

Pre-interview Questionnaire

Survey Flow

Q1.0 ***Do you work as a clinical psychologist (either part-time or full-time) within the public-sector in the province of Quebec?***

- Yes (1)
- No (4)

M1.0
Regrettably, you don't meet the inclusion criteria for the present study as it aims to understand the experiences of clinical psychologists in the public sector.

However, if you are a clinical psychologist with a private-practice, you may be eligible for future studies and we would like to keep in touch. Please indicate your email address if you are interested. *You are not obliged to agree but of course we hope you will.*

Q1.1 **INFORMATION AND CONSENT TO PARTICIPATE IN A RESEARCH STUDY** I understand that I am participating in a research study being conducted by Alexandra Panaccio, Doctor of Philosophy, (514-848-2424 x2929, alexandra.panaccio@concordia.ca), Dr. Andrew G. Ryder, psychologist, and Ingrid Chadwick, Doctor of Philosophy, from Concordia University.

A. PURPOSE

We are conducting a study investigating the well-being of mental-health practitioners.

B. PROCEDURES

This research consists of 3 stages. First, you will respond to an on-line questionnaire (approx. 12-15 min). Next, a 1-hour interview will be conducted at a time and place of your convenience, e.g. in your office at the end of the workday, over Skype or telephone. Finally, if needed, a 15-min. telephone interview will be scheduled a week later to clarify discussion from the main interview. In total you will be compensated $90 (Amazon gift card) for ninety minutes of your time.

C. RISKS AND BENEFITS

The researchers do not foresee specific risks associated with participating in this research, other than possible emotional discomfort resulting from reflecting on, and answering survey items about one's psychological wellbeing. There are no personal benefits other than the personal insights gained from taking part in psychological/organizational-behaviour research.

D. CONFIDENTIALITY

The information collected will remain strictly confidential (i.e., the research team will know, but will not disclose your identity), and only aggregated results will be shared. Only members of the research team will have access to this information and data will be stored on password-protected USB drive and computer. However, to verify that the research is being conducted properly, regulatory authorities may examine the aggregated information gathered without knowing your identity.

E. CONDITIONS OF PARTICIPATION

I understand that I am free to withdraw my consent and discontinue my participation at any time. I can also ask that my data not be used by notifying the researcher within two weeks after having participated, and my choice will be respected. There are no negative consequences for not participating, stopping in the middle, or for asking the researcher to not use your information. I understand that my participation in this study is confidential (i.e., the research team will know, but will not disclose my identity). I understand that aggregated data from this study may be published in academic journals and conferences, without disclosing my identity. Upon request, the researchers will send me copies of the scientific articles and communications published based on these data.

I HAVE CAREFULLY STUDIED THE ABOVE AND UNDERSTAND THIS AGREEMENT. I FREELY CONSENT AND VOLUNTARILY AGREE TO PARTICIPATE IN THIS STUDY. CLICKING THE BUTTON BELOW AND COMPLETING THIS SURVEY CONSTITUTES CONSENT ON MY PART.

If at any time you have questions about your rights as a research participant, please contact Research Ethics and Compliance Officer, Concordia University, at 514-848-2424 x7481 or by email at ethics@alcor.concordia.ca

Thank you Your collaboration is important for the success of this project, and the research team thanks you for participating.

Consent For a downloadable pdf of this form, click: Consent Form. By clicking the « I agree » button below, you declare that you: a) voluntarily agree to participate in this research study; b) understand the goals of this research and what your participation entails; c) understand that your participation in this research is completely voluntary and that you can withdraw from this research at any time, without any negative consequences, and without having to justify your decision.

○ I AGREE

Skip To: Q1.2 If INFORMATION AND CONSENT TO PARTICIPATE IN A RESEARCH STUDY I understand that I am participating i... = I AGREE

Q1.2 **INSTRUCTIONS** *The following code will be used to keep your data anonymous.* ***In addition, at the end of this survey we will ask you whether you wish to participate in future research projects****. You are not obliged to agree but of course we hope you will. The code will also be used to anonymously match your responses today with your future responses if you do participate in future research studies.*

Q1.3 *Participant Code:*

What is the last letter of your first name? _____

What is the last letter of your family name? _____

What is the day of the month you were born in? (a number from 01 to 31) _____

What is the last letter of your mother's first name? _____

What is the last letter of your mother's original family name? (maiden name) _____

QA1 **SECTION A: INDIVIDUAL & TEAM CHARACTERISTICS** Gender

Male

Female

Other

QA2 ***How long have you been practicing as a clinical psychologist? (number of years)*** _____

QA4 ***What is your employment status at the CIUSSS?***

- ○ Full-time
- ○ Part-time

QA3 ***Please indicate the healthcare setting that you work in:***

- ○ Primary Care
- ○ Specialized Services
- ○ Both Primary Care & Specialized Services

Display This Question:

If Please indicate the healthcare setting that you work in: = Primary Care

Or Please indicate the healthcare setting that you work in: = Both Primary Care & Specialized Services

QA3.1a ***Primary Care Team Setting***

- ☐ Out-patient Clinic
- ☐ Adult Mental Health Primary Care Team
- ☐ One-Stop Service Team
- ☐ Intensive Case Management Team
- ☐ Rehabilitation Team
- ☐ Other

Display This Question:

If Primary Care Team Setting = Other

QA3.1b ***Please indicate the team setting(s) you work in.*** _____

Display This Question:

If Please indicate the healthcare setting that you work in: = Primary Care

QA3.1c ***Please indicate ...***

- ○ The number of professionals in your team: _____
- ○ Your seniority in the team (# of years): _____

Display This Question:

If Please indicate the healthcare setting that you work in: = Primary Care

QA3.1d ***Team composition (please select all that apply)***

- ☐ Psychologists
- ☐ Social workers

- ☐ Nurses
- ☐ General practitioners
- ☐ Psychiatrists
- ☐ Occupational therapists
- ☐ Psycho-educators
- ☐ Substance Use Disorder Specialists

Display This Question:

If Please indicate the healthcare setting that you work in: = Specialized Services

Or Please indicate the healthcare setting that you work in: = Both Primary Care & Specialized Services

QA3.2a ***Specialized Services Team Setting***

- ☐ In-patient Unit
- ☐ Out-patient Clinic
- ☐ Rehabilitation Team
- ☐ Intensive Case Management Team
- ☐ Assertive Community Treatment Team
- ☐ Other

Display This Question:

If Specialized Services Team Setting = Other

QA3.2b ***Please indicate the team setting(s) you work in.***_____

Display This Question:

If Please indicate the healthcare setting that you work in: = Specialized Services

QA3.2c ***Please indicate …***

- ○ The number of professionals in your specialized services team: _____
- ○ Your seniority in the specialized services team (# of years): _____

Display This Question:

If Please indicate the healthcare setting that you work in: = Specialized Services

QA3.2d ***Specialized services team composition (please select all that apply)***

- ☐ Psychologists
- ☐ Social workers
- ☐ Nurses
- ☐ General practitioners
- ☐ Psychiatrists
- ☐ Occupational therapists
- ☐ Psycho-educators
- ☐ Substance Use Disorder Specialists

Display This Question:

If Please indicate the healthcare setting that you work in: = Both Primary Care & Specialized Services

QA3.3a ***Please indicate …***

- ○ The number of professionals in your primary team: _____
- ○ Your seniority in the primary care team (# of years): _____
- ○ The number of professionals in your Specialized Services team: _____
- ○ Your seniority in the Specialized Services team (# of years): _____

Display This Question:

If Please indicate the healthcare setting that you work in: = Both Primary Care & Specialized Services

QA3.3b ***Team composition (please select all that apply)***

	Primary Care	Specialized Services
	Yes (1)	Yes (1)

Psychologists	○	○
Social workers	○	○
Nurses	○	○
General practitioners	○	○
Psychiatrists	○	○
Occupational therapists	○	○
Psycho-educators	○	○
Substance Use Disorder Specialist	○	○

QB0 Please indicate your average caseload size:

QB1 **Client Characteristics**

Please indicate the Mental Health problems that you commonly treat … (select all that apply)

- ☐ Common mental disorders (Depression; anxiety)
- ☐ Severe mental disorders (bipolar; psychotic etc.)
- ☐ Personality disorders
- ☐ Co-occurring Mental Health Disorder & Substance Use Disorder
- ☐ Co-occurring Mental Health Disorder & Physical Disorders

QB2 ***Additional clinically relevant variables (select all that apply)***

- ☐ Suicidal ideation
- ☐ Problems with justice system
- ☐ High service user
- ☐ Significant trauma
- ☐ Young Persons with Problems

QB3 ***Regarding your work activities, how much time do you spend per week doing the following tasks: (total should add up to 100)***

Client assessment: _____

Case management: _____

Psychotherapy/counseling: _____

Administrative/clerical: _____

Co-ordination with other teams: _____

Clinical supervision: _____

Travel time: _____

Total: _____

QB4 ***Do you use the following approaches in your clinical practice? (hover over the word for definition)***

	1 No & not considered	2 No, but considered	3 Yes
Cognitive Behavior Therapy	○	○	○
Motivational Interviewing	○	○	○
Care Pathways	○	○	○
Recovery Approach	○	○	○
Strengths Model	○	○	○
Self-management	○	○	○
Stepped care	○	○	○

QB5
Do you use the following tools in your clinical practice?

	1 No & not considered	2 No, but considered	3 Yes
Screening tools for diagnosing mental health disorder	☐	☐	☐
Assessment tools for mental health disorder	☐	☐	☐
Screening tools for diagnosing substance use disorder	☐	☐	☐
Assessment tools for substance use disorder	☐	☐	☐
On-going treatment assessment tools	☐	☐	☐
Patient satisfaction	☐	☐	☐
Clinical protocols or Best-practice guidelines	☐	☐	☐
Clinical feedback assessment	☐	☐	☐

QD We appreciate any comments you may have about this questionnaire in general and about ways you think we might improve it.
(Also, if you would like to be contacted by our research group for participation in future studies, please let us know in the following comments box.)

Appendix A-2

Introduction (1~2 min)

Healthcare workers in Montreal encounter complexity on a daily basis. The purpose of this interview is to understand 2 aspects of this complexity.

First, I want to understand from ***your*** perspective, the demands on your job as a clinical psychologist in primary care and the resources that are available to meet those demands*. [use the visual aid and go over the different categories of job demands & resources (JD-R) and encourage participants to refer to it during the interview]*

Second, I want to know about ***your*** experience in serving Montreal's culturally and linguistically diverse patient population.

Please note that there are ***no*** right or wrong answers.

Professional History (2~3 min | 58 min)

Before we get to the main interview, I'd like to know a little bit about your professional journey.

1. Can you share, key professional experiences that led you to your current role.

Patient Demands (4~5 min | 55 min)

Patient (Illness) Characteristics	
B1: Common Diagnoses	*Common Mental Health Disorders (MHDs)* | *Severe MHDs* | *Co-occurring Disorders*
B2: Other Clinical Variables	*Suicidal ideation* | *Problems with justice system* | *Significant trauma* | *High service users*

2. I see that you commonly treat patients with [**insert B1 & B2: Common Diagnoses with Other Clinical Variables**]. What are some of the demanding aspects of treating these patients?

Good Answer: ***Physical****: high caseload* |→ ***Psychological:*** *illness complexity, *cognitive & emotional demands, *time & work pressure* |→ ***Social:*** *difficult contacts with patients (violence, harassment, conflict, misbehaviour)* |→ ***Organizational****: performance demands, problems planning/coordinating*

Job Demands & Resources associated with Teamwork (6~8 min | 50 min)

Following 2005 Mental Health Reform, psychologists in primary care are required to work in *interdisciplinary teams

Setting	
A3*:* Healthcare Setting	*Primary Care (PC)* | *Specialized Services (SS)* | *PC & SS*
A3.1: Team Setting	**PC***: MH-PCTs* | *1-Stop Services* | *Intensive Case Management (ICM)* | *Rehabilitation Team (RT)* **SS***: In/Out-patient Clinic* | *ICM* | *RT* | *Assertive Community Treatment (ACT)*

3. As a clinical psychologist, what are some of the demanding aspects of working in an interdisciplinary team?

*[When eliciting response to the demands/resources, draw the participant's attention to the visual aid and wait. If there is no response, then nudge by reading the **Good Answer** in its entirety and ask the question: 'Do any of these examples are relevant to your experience of working in a team?]*

Good Answer: ***Physical****: geographical distance* |→ ***Psychological****: autonomy, diagnostic conflict,* |→ ***Social****: interpersonal conflict with colleagues* |→ ***Organizational****: staff shortage, high turnover, problems-planning & coordinating*

3.1. Probe: Over long term, which of these demands require additional effort on your part?

3.2. Probe further: Do you consider these factors to be *challenges or *hindrances?

[Examples of challenges include demands such as a high caseload, time pressure, and high levels of job responsibility. Examples of hindrances include demands such as role ambiguity, organizational politics, red tape, and hassles]

4. What resources are lacking that make it difficult to work in an interdisciplinary team?

Having discussed the demanding aspects of working in teams, let's look at resources now. We know that various resources are required to work effectively in an interdisciplinary team. With this in mind,

5. Presently, what functional resources are available to you that enable you to effectively work in interdisciplinary-teams?

Good Answer: *Human resources (quotas of psycho-social professionals and GPs in PC)* |→ *Material resources (i.e. shared clinical records, network resource directory, referral procedures, testing equipment/tools)* |→ *Policies on service offerings and service eligibility (i.e. criteria governing client referrals to primary versus specialized care)*

Job Demands & Resources associated with Teamwork (Contd.| 6~8 min.| 50 min)

5.1. Probe: Are there aspects of working in an interdisciplinary team that motivate you?

Good Answer: *Leadership commitment to mental-health* |→ *Social support from colleagues & supervisors* |→ *Participative decision-making* |→ **Team-cohesion & harmony within your team* |→ *continuity of care*

5.2. Probe: Are there aspects of working in an interdisciplinary team that stimulate personal growth or professional development?

Good Answer: **Shared-training* |→ *Interdisciplinary exchange/ knowledge transfer* |→ *Performance feedback*

6. Are there any other resources we haven't discussed that make it easier to work in a team?

Job Demands & Resources Associated with Shared-Care (6~8 min|42 min)

To improve quality of MH services in primary care, the Ministry promoted shared-care by hiring respondent-psychiatrists to provide consultation and support to psychologists.

Shared-care	
C2: Respondent Psychiatrist	**Frequency of interactions**: *Low*| *Medium*| *High;* **Satisfaction**: *Low*| *Medium*| *High;*

7. From your perspective, what are some of the demanding aspects of collaborating with a respondent-psychiatrist?

*[When eliciting response to the demands/resources, draw the participant's attention to the visual aid and wait. If there is no response, then nudge by reading the **Good Answer** in its entirety and ask the question: 'Do any of these examples are relevant to your experience of collaborating with psychiatrists?]*

Good Answer: ***Physical****: case overload* |→ ***Psychological****: *work & time pressure, paradigm/diagnostic differences* |→ ***Social****: interpersonal conflict* |→ ***Organizational****: shortage of respondent-psychiatrists, problems planning/co-ordinating, lag time*

7.1. Probe: Over long term, which of these demands require additional effort on your part?

7.2. Probe further: Do you consider these factors to be *challenges or *hindrances?

[Examples of challenges include demands such as a high caseload, time pressure, and high levels of job responsibility. Examples of hindrances include demands such as role ambiguity, organizational politics, red tape, and hassles]

8. What resources are lacking that make it difficult to collaborate with a respondent psychiatrist?

Job Demands & Resources Associated with Shared-Care (Contd.| 6~8 min|42 min)

Just as before, having discussed the demands, let's look at resources now. We know that it takes resources to facilitate collaboration and advance shared-care. With this in mind,

9. Presently, what functional resources are available to you that enable you to meaningfully collaborate with respondent-psychiatrists?

Good Answer: *Easy access to a respondent-psychiatrist* |→ *Procedures on conducting consultations* |→ *Policies on conflict resolution*

9.1. Probe: Are there aspects of working with respondent-psychiatrists that motivate you to collaborate with them?

Good Answer: *Joint-responsibility* |→ *Pre-existing relationships (i.e. previous contact with psychiatrists)* |→ *Trust/Appreciation*

9.2. Probe: Are there aspects of working with a respondent-psychiatrist that stimulate personal growth or professional development*?*

Good Answer: **Shared-training* |→ *Skill-utilization* |→ *Enhanced expertise*

10. Are there any other resources we haven't discussed that make easier to collaborate with a respondent psychiatrist?

Job Demands & Resources Associated with Best-Practices (6~8 min | 34 min)

To improve quality of MH services in primary care, the Ministry also recommended best-practices such as evidence-based clinical approaches (such as CBT) and standardized procedures (such as screening tools).

Quality Tools	
B4: **Clinical Approaches** → *CBT | *Stepped-care | *Motivational Interviewing | *Strengths Model | *Care Pathways | *Self-management | *Recovery Approach	***Frequently Used**:* ***Less frequently Used**:*
B5: **Standardized Procedures** → *Screening tools for MHDs | *Assessment tools for MHDs | *Assessment tools for client satisfaction | *Clinical protocols | *Best practice guidelines	***Frequently Used**:* ***Less frequently Used**:*

11. What are some of the demanding aspects of incorporating these best-practices in your clinical work?

*[When eliciting response to the demands/resources, draw the participant's attention to the visual aid and wait. If there is no response, then nudge by reading the **Good Answer** in its entirety and ask the question: 'Do any of these examples are relevant to your experience of integrating best-practices?]*

Good Answer: ***Physical**: illness complexity* |→ ***Psychological:** *time & work pressure, beliefs about theories of treatment* |→ ***Organizational**: performance demands*

11.1. **Probe:** Over long term, which of these demands require additional effort on your part?

11.2. **Probe further:** Do you consider these factors to be *challenges or *hindrances?

[Examples of challenges include demands such as a high caseload, time pressure, and high levels of job responsibility. Examples of hindrances include demands such as role ambiguity, organizational politics, red tape, and hassles]

12. What resources are lacking that make it difficult to integrate these best-practices in your clinical work?

Job Demands & Resources Associated with Best-Practices (Contd.| 6~8 min|34 min)

Having discussed the demands, let's look at resources. Just as before, we know that it takes resources to support the uptake of best-practices and improve quality. With this in mind,

13. Presently, what functional resources are available to you that enable you to incorporate these practices in your clinical work?

> ***Good Answer:*** *Guidelines on clinical-screening and evaluation tools* |→ *Protocols on clinical processes for treatments* |→ *Outcome assessment framework (e.g. indicators for MH service evaluation)*

13.1. **Probe:** Are there aspects of using these best-practices that motivate you to incorporate them in your clinical practice?

> ***Good Answer:*** *Social recognition* |→ *Management Support* |→ *Procedural fairness*

13.2. **Probe:** Are there aspects of using these best-practices that stimulate professional learning and development?

> ***Good Answer:*** *Training* |→ *Skill-utilization* |→ *Performance feedback*

14. Are there any other resources we haven't discussed that make easier to integrate these best-practices in your clinical work?

Leadership (6~8 min|26 min)

15. How do you feel that the leadership has been throughout this process with respect to organizing the effort?

> ***Good Answer:*** ***Organizing the effort****: Clear communication plan (re: mission & strategy to achieve MH Reform objectives* |→ *Adequate human & material/technological resources* |→ *Clearly defined: roles and responsibilities, levels of authority, operating procedures, performance objectives* |→ *Service Agreements with healthcare organizations within the local service network

16. How do you feel that the leadership has been throughout this process with respect to supporting members?

> ***Good Answer:*** ***Supporting members****: Leadership support & commitment to support mental health professionals* |→ *Procedures for decision-making and conflict-resolution* |→ *Protocols for the provision of materials, equipment, technology* |→ *Social and safety climate* |→ *Training & reward infrastructure to promote professional development and culture of collaboration* |→ *Performance Feedback*

Cultural and Linguistic Diversity in Clinical Practice (6~8 min | 18 min)

In terms of the skills you have difficulty with when working with French-speaking clients…

17. What is it that makes [**mention what they reported as 5 or greater on a scale of 10 in terms of competency**] challenging?

Probe:

- ➔ *If the participant mentions anything about the **language** or the **cultural differences** between him/her and their clients, probe further about **what it is about these differences** that makes it difficult for them to be competent in terms of the context in question.*
- ➔ *If the participant does not mention **language or cultural difficulties** (or one of these is not mentioned), then probe with the following questions:*

17.1. Does some of this challenge come from the **language differences** between you and the client? What is it about these language differences that makes it difficult for you?

17.2. Does some of this challenge come from the **cultural differences** between you and the client? What is it about these cultural differences that makes it difficult for you?

[*repeat 17, 17.1., and 17.2. for each context that was challenging (5 or greater on a scale of 10 in terms of competency as reported in the online questionnaire)].*

18. Do you think you have sufficient training to address these challenges as they relate to language and/or cultural differences? What other training do you wish you had access to?

19. Do you think you have sufficient practical resources (interpreters, culture brokers, access to documentation, etc.) to address these challenges as they relate to language and/or cultural differences? What other practical resources do you wish you had access to?

Note: *Make sure that the participant addresses training/resources that they wish they had access to as they pertain to **all of the challenges they just mentioned.** These challenges might have to be reminded or summarized to the participant as they answer these questions.*

Note 2.: *If the participant does not work with clients in French, instead of asking **question 18**, ask them this: "If you had to work with clients in French, what would be the challenges associated with **language** and **culture** for you?"*

Well-being & Burnout (8~10 min | 10 min)

We have been talking about the challenges of working in primary care and resources available to meet those demands. I'm wondering if we can conclude this part by talking about:

Alternatively: [*make a spontaneous summary of things that have come up during the interview*] OR [*If they mention something about burnout in the interview reflect it back to them by stating: '***You mentioned** (*insert their comment about burnout/emotional exhaustion or job-related stressors/depersonalization or mental distancing/reduced personal accomplishment*)]

20. How is it affecting your work with clients?

21. What impact has it had on your wellbeing?

22. How has it affected your job satisfaction?

Common Scenarios

- **IF someone gives just-the-facts answer → THEN follow-up with:**
  - Can you tell me more about that?
  - Can you give me an example of [insert the concept they are referring to]
  - What was that like for you?
- **IF someone talks too much → THEN follow-up with:**
  - Thanks, that's been very helpful, what I would like to do next is [move on to next question]

- **Care pathways:** Systematic interventions planned for integrating care between different organizational units or between providers for a well-defined group of clients and treatment periods. Originally established for acute medical care, for which it has been proven effective. This care process aims at enhancing continuity of care and system efficiency, and is also applied currently in MH.
- **Case overload:** Amount of work an individual has to do. There is a distinction between the actual amount of work and the individual's perception of the workload. Workload can also be classified as quantitative (the amount of work to be done) or qualitative (the difficulty of the work). It depletes the capacity of people to meet the demands of the job.
- **CBT**: Psychotherapy aiming to change thinking and behavior. Effective for most mental health disorders, including SUD.
- **Cognitive demands:** tasks involving making connections, analyzing information, and drawing conclusions." (Smith & Stein, 1998)
- **Complexity:** complexity is a quality of changing patterns and patterns of change,
- **Emotional demands:** dealing with strong feelings such as sorrow, anger, desperation, [and] frustration" at work
- **Individualized service plans:** Mutual agreements among service providers, the client or his/her representative (or family) defining which care or service objectives to pursue. Plans usually target clients with multiple and often severe needs, who require case coordination involving several providers.
- **Interdisciplinary**: integrating knowledge and methods from different disciplines, using a real synthesis of approaches.
- **Liaison officer:** Professional designated by an organization to relay information between departments of the same organization, or between organizations serving the same clientele
- **Motivational interviewing:** Brief intervention aiming to engage motivation to change behavior. Mainly effective for substance use disorders.
- **Recovery approach:** Personal journey that involves developing a secure sense of self, supportive relationships, empowerment, social inclusion, coping skills, and new meaning in life.
- **Referral mechanisms:**
  - Network resources directory
  - Referral procedures between organizations
  - Referral procedures within organizations
  - Shared clinical records
- **Safety climate**: is the perceived value placed on **safety** in an organisation at a particular point in time. These perceptions and beliefs can be influenced by the attitudes, values, opinions and actions of other workers in an organisation, and can change with time and circumstance.
- **Self-management:** Systematic provision of education and supportive interventions in order to increase skills and confidence of clients in managing their health problems. Mainly effective for depression.

- **Service agreement:** Administrative strategy used in formalizing mechanisms that facilitate access and continuity of services between at least two organizations, or between programs in the same organization.
- **Shared staff:** Professionals offering services across more than one organization to insure coverage of the required range of services and to intensify inter-organizational collaborations.
- **Shared training:** A strategy to enhance collaborative environments by simultaneously training clinicians with different areas of expertise, and/or from different services or organizations in a network.
- **Stepped-care:** Care delivery model in which interventions are performed hierarchically based on the intensity of client problems. Mainly effective for depression.
- **Strengths model:** Intervention focusing on the strength and interests of the user rather than pathology, and oriented toward achieving goals set by the user him/herself. Mainly effective for severe mental health disorders.
- **Team cohesion:** Team cohesion happens when a team remains united while working to achieve a common goal. Being a cohesive team means that not only are group goals met but everyone feels like they have contributed to the overall success of the group. Individuals on a cohesive team tend to focus more on the entire group rather than their individual selves and are more motivated to work towards the team goal.
- **Team harmony:** Each individual involved in a team has a different way of doing one thing, which can create teamwork issues for a number of different aspects. Most people don't appreciate that employee cooperation involves more than just working together to 'get the job done', but more importantly should focus on achieving results through each employee's contributions.
- **Time pressure**: Time pressure is a type of psychological stress that occurs when a person has less time available (real or perceived) than is necessary to complete a task or obtain a result.
- **Work pressure**: Work pressure is the pressure which you experience at work. With pressure we mean that you must finish a certain number of tasks within a certain timeframe. Work pressure thus is when you experience pressure, because you have to properly finish a certain number of tasks by a specific time. You thus are under pressure to keep to a certain deadline. You also experience pressure because the tasks which you finish have to be done correctly. You cannot just deliver anything, it must be entirely as your client/your boss expects it to be.
- **Challenge Stressors** tend to be appraised as stressful demands that have the potential to promote mastery, personal growth, or future gains. Examples of challenges include demands such as a high workload, time pressure, and high levels of job responsibility. Employees tend to perceive these demands as opportunities to learn, achieve, and demonstrate the type of competence that tends to get rewarded.
- **Hindrances Stressors** tend to be appraised as stressful demands that have the potential to thwart personal growth, learning, and goal attainment. Examples of hindrances include demands such as role conflict, role ambiguity, organizational politics, red tape, and hassles. Employees tend to perceive these demands as constraints, barriers, or roadblocks that unnecessarily hinder their progress toward goal attainment and rewards that accrue as a result of being evaluated as an effective performer.

Appendix C-A

Burnout Group A: P-1 (Team Demand)

- Ref_1: TD-Phy (**Administrative workload**)

  Oh, yeah, sometimes we have to do referrals and it takes the time, it's just the paperwork, it's like… I know my coworker will take the client, we discuss it, but we have to do the paperwork. That's it.

- Ref_2: TD-RL (**in-depth inter-disciplinary group supervision**)

  Umm, we used to have--- we call it group supervision, so where we would go deeper in either a theme, or topic, or about a client. But now, they want us to do those meetings with… you know, by profession… So I have to travel to wherever and go, and do like, do that with psychologists, but, I used to… prefer do that with my team [sic] cause we--- We really work well together. So, it---It's interesting with the psychologists, it's just that… yeah--- I'm used to my---my interdisciplinary [sic]. So, those meetings were very important, we still have them every week but it's quicker. We don't go as deep as we used to.

- Ref_3: TD-Org (**geographical distance, problems planning & coordinating off-site meetings**); TD-RL (**team-cohesion**)

  They are mandatory. What's interesting was: it took a time like, to get used to each other… cause we are like, four different CLCS, it was difficult to, umm, find meeting schedule that would… accommodate everyone, cause some people are working just two days [sic]. I'm working, you know… So, we had to--- yeah [inaudible 18:09:00-18:12:00]. There's also, you know, approach differences, and, uhh--- So we're still working on… maybe building an alliance as a group alliance in, umm, and we felt there was this, you know, mandatory thing [sigh]. One of them, there was so many in--- since the you know, I don't know [inaudible 18:33:03-18:35:50]. I'm not sure if it's just from 2005 cause it's--- I've worked here since 2005, but I've seen changes since the…maybe last three…four years.

- Ref_4: TD-Org (**work overload**)

  P-1 also expressed frustration with frequency of requests from senior management in the last 3 to 4 years. There was really a switch. But, a change, yeah--- mostly in management and in their demands they [inaudible 18:55:05-18:57:00]. Demands, demands, demands, like---

- Ref_5: TD-RL (**team cohesion**)

  So, it's interesting with the psychologists but it's… maybe I'm nostalgic of the time that, you know… that it worked so well, we just, are a little team and, it--- yeah.

- Ref_6: TD-RL (**in-depth inter-disciplinary group supervision**)

  Yes, and also multi-angles the mul---

  I: Multidisciplinary---

  P: Yeah, not just intra-psychology angle [inaudible 19:41:55-19:44:07]. You know, it was more… like, the questions would be more… holistic I would say.

- Ref_7: TD-Org (**job creep; skill utilization**): This reference is related to demands associated with practices such as group psychoeducation. P felt running psychoeducation groups could be done by 'technicians' and under utilizes her skills (not what she was trained for 5+ years)

  Like, giving the psychoeducation material… at that point it was repetitive. It was like "Okay we'll just… do this exercise blablablah"; and it was less of a… therapeutic setting?

… and I feel like we--- You don't need professionals to do that. You might need… I don't know… I don't want to be derogatory, but, like, you don't need special skills to give a group and just give information. You just give the information, and c'est tout….

Burnout Group A: P-1 (Team Resources)

- Ref_1: TR-Motiv

  I love it.

- Ref_2: TR-Motiv

  Oh, for me it's umm, the resource [inaudible 12:13:10-12:16]. Oh my god, I just love it!

- Ref_3: TR-Func/Motiv

  I can go to my team whenever I feel stuck, whenever I frustrated, whenever I feel like I have no clue, I'll go to---. We have regular meetings on Thursday, and I'm the only psychologist but there are a lot of psychotherapists, social workers.

- Ref_4: TR-Func/Motiv

  Because, maybe, because my mom was , like [a social worker], I have no issue with like--- We work similarly. We may not have the same background, we work similarly so I've got like great input from my coworkers, great support, I give support. So, it's just lovely. It's just very, very important. Umm… and sometimes we do, umm…We work together with the same client, but not like, we work separately, but we all consult a lot, so while we work-

- Ref_5: TR-Func/Motiv

  [so] With work in the addiction, while I work on anxiety or depression or personality. Or there's the occupational therapist working on skills to go back to work, while I'll work on whatever other issues, but---. We consult a lot

- Ref_6: TR-Motiv

  It's wonderful.

- Ref_7: TR-Motiv

  It changes everything that's what I've been saying here for so long.

- Ref_8: TR-Motiv

  Because my team is just incredible.

- Ref_9: TR-Motiv

  There's really a--- but we don't always agree, we have to like, sometimes work through our, uhh, disagreement, but, uhh… Yeah, it's a big plus. It's… for me it's everything

- Ref_10: TR-Motiv

  it's a source of motivation and support.

- Ref_11: TR-PD

  Oh yeah, learning a lot, I often would quote my occupational therapist's coworker and say: "You know, part of the [inaudible 15:04:04-15:05)0.4]". Getting back into le rétablissement, you're not fully, like re-établir {re-establish}… but it will be through work. Some, and kind of like taking some notions that she will work with on the client, and--- integrate it in my own practice.

- Ref_12: TR-PD

I was not exposed to cause we don't talk about like, anyway, like---. When I was trained, like "How do you decide that a client is ready to go back to work?". How do you, kind of remediate to some aspects of like, you know, like, of concentration and stuff. She would tell me [laughing]. Or like, work with a client, but, umm… I'm learning a lot.

- Ref_13: TR-PD

  Social workers, uhh, you know, even nurses, like, their--- Are doctors even the psychiatrists? I'm learning almost every week

- Ref_14: TR-PD

  About meds, about, like… body and mind, and whatever. I'm--- so it's, yeah—

- Ref_15: TR-Func

  [I: So, is---So there is an element of like, uhh, personal and professional growth that---

  P: Yes!

  I: That comes with working in a team, where there is knowledge being shared between different professions.]

  Yes, we have different angles, and so, it's more rich [sic]… about a client

<u>Burnout Group A: P-10 (Team Demand)</u>

- Ref_1,2:TD-Org (l**ack of support for CPs)**; TD-Psy **(emotionally heavy**)

  P-10 noted that a year and a half ago, there were interdisciplinary meetings so psychologists, social workers and specialized educators. But the support for psychologists was not necessarily there. That is to say, it was more the psychologists who supported the whole team. And that got very heavy

- Ref_3: TD-Org (**additional work responsibility**); TD-Phy/Psy (**experience burnout and depression**)

  P-10 reported that today it's very different. But back then, in addition to the caseload and the amount of requests, her coordinator, her team leader as well... Asked that psychologists work with the open door to be able to meet the requests of and support social workers and specialized educators. So it became very heavy. P-10 fell ill and experience burnout within her 1st year of working in a CLSC. She was diagnosed with depression and had to go on anti-depressants. She stopped working for approximately 7 months. It was too much and she did not have adequate resources or support for herself. Eventually, she sought help an employee [assistance] program but it was too late and she was already in a depression.

- Ref_4: TD-Org (**additional work responsibility to support colleagues**); TD-Phy/Psy (**experience burnout and depression**)

  [the additional responsibility of] supporting social workers and specialized educators …was too much.

- Ref_5,6: TD-Org (**inadequate human resources; work overload**)

  P-10 noted that due to restructuring she found herself working alone in the department. First, the management removed the navigator nurse whose job was to accept the applications. Consequently, another psychologist took on the nurse's workload. And the psychologist in charge went on maternity leave. This is how, very quickly P-10 became overloaded with work

- Ref_7: TD-Org (**offsite meetings are inconvenient; lack of professional support**):

  In response to whether they take additional effort, P-10 noted that the meetings are less pleasant because they are outside and we all have to travel. And these are the meetings that all psychologists in the CIUSSS Capitale-Nationale region must attend. So, we don't know each other. So it's hard to support each other. So, we go to meetings, it revolves a lot around questions about what is coming. But we don't have the opportunity to offer each other our own support. No, it exists more, it's like private. But we have access to all the schools in the CISSS Capitale-Nationale region.

- Ref_8: TD-Org (**missed opportunity for supervision**)

  In response to whether the meetings among psychologists are a hindrance or a challenge, P-10 said they are neither. Neither one of them because they're information meetings, so it's not that difficult. However, at the organizational level, it would be possible to receive this information by videoconference. So, it's more the displacement that bothers. we don't discuss cases or issues concerning mental health treatment per se, instead it is more of an information session during which they review topics like "What are the services aligned to, what has the government made changes, where are we going, what's coming, what you're going to need to be trained..."

- Ref_9: TD-Chal: ~~Phy~~ Org (**additional workload**): P-10 stated that psychologists have been asked to conduct evaluations for autism spectrum disorder (TSA: trouble du spectre de l'autism), in addition to doing psychotherapy. And even though they will be trained to do these evaluations, the coordination/delivery of these two types of services will add to the workload (challenge)

  PQPTM: Programme québécois pour les troubles mentaux

- Ref_10: TD-RL (**social support**): P-10 also stated that in general social support from colleagues is a resource that is lacking. P-10 did note that its difficult but with permission from the program manager it is possible because they tried to do this (i.e. help each other during meetings) in the past but it is difficult to find time. There are no formal opportunities to support each other. However, colleagues informally support each other when they sense that someone is not doing well or if they are tired by checking in on them and asking them to take rest or go for a consultation. They don't go beyond that and there is a sense that this is superficial and it feels like 'private' practice

- Ref_11: P-10 is not suggesting that someone (e.g. manager) should have the additional responsibility of supervising psychologists but rather they would be responsible for bringing psychologists together so that they can support each other (as they do in a school environment).

- Ref_12: TD-RL (**interdisciplinary training**): P-10 expresses that in an ideal world there would be interdisciplinary training meetings in an interdisciplinary environment like (Sacré-Coeur) a hospital where there would be child psychiatrists, social workers etc. and they would have the opportunity to discuss cases or things like that more broadly. In fact people are experimenting and its mostly young people who start. Their training is fresh in their heads and they have a very interesting perspective on conducting evaluations. And it's very helpful when you combine that with the wealth of knowledge from people who have been on the floor and who have seen many cases

- Ref_13: TD-Org/RL (**inadequate human resources**); -Phy (**high/increase workload**): P-10 noted that they used to have a nurse coordinator that would liaise with the CLSC, parents, and the hospital center but this position is being eliminated in her territory/LSN. And now this coordination work falls under psychologists. (This may be due to her geographical area)

<u>Burnout Group A: P-10 (Team Resources)</u>

- Ref_1: TR-Func (**Psychologists**)

  P-10 noted that things changed a lot when she came back from sick leave. The management rehired three more psychologists and so the workload is better distributed among them. And they also pay attention to the types of cases so that no one psychologist ends up with all suicidal cases.

- Ref_2: TR-Func **(role clarity**); TR-Oth (**non-clinical workload)**

  P-10 reported that things are better now that they have hired 3 other psychologists. The P-10 no longer required to support social workers and specialized-educators. The teams have now been divided such that the social workers and specialized educators are under the supervision of their coordinator, and they meet about once a month to support each other.

- Ref_3: TR-Func (**professional/primary-care meetings**)

  P-10 explained that on the side of psychologists, they meet once every 3 months. These are informational meetings on what's coming, including CLSC and redevelopment projects. That's how it is. P-10 indicated that it's not necessarily a support meeting, although they can always ask for an appointment for a meeting with their clinical leader (chef clinicien) in order to talk about a problem they are facing and get an answer to a question. P-10 also reported that as psychologists they offer primary care meetings, which is also something new. At these meetings there are psychologists, social workers, nurses, and nurse navigators that are there to hear cases from social workers or specialized educators in order to support them. So it's more structured. In terms of our own support, P-noted that they have to seek it outside…

- Ref_4: TR-RL (**professional support**)

  [contd.] … and she is paying a psychologist right now for psychological support.

- Ref_5: TR-Oth (**employee assistance program**)

  P-10 reported that the resource she is currently using is the employee assistance program.

- Ref_6: TR-RL (**professional support**)

  P-10 repeated that she is working with a psychologist and will continue follow up with them afterwards

- Ref_7: TR-Motiv

  According to P-10, working in an interdisciplinary team (which includes social workers, specialized educators and psychologist) in a big plus. P-10 works as team. For example, if she is doing psychotherapy with a young person and sees no improvement in their depression but sees problems at the family-level, she quickly involves a social worker. She holds consultation meetings with them and really works with her colleagues as a team. P-10 also said that they support each other and make recommendations to help each other do their jobs better, in order to better help the client

- Ref_8: TR-Motiv

  P-10 expressed that she finds interdisciplinarity to be very motivating. It is one of the reasons she prefers working in public healthcare system instead of private.

- Ref_9: TR-Func (interdisciplinary consultation meeting)

  P-10 explained that when she is on a case with a team, she and her colleagues on the team will set up a consultation meeting to work together on a treatment plan. In addition, P-10 also talked about primary-care meetings (that she mentioned previously) in which she listens to cases from colleagues that are not on her team and offers them support because they need help

- Ref_10: TR-Func (primary-care meetings)

  P-10 explained that the primary-care meetings are planned in a calendar beforehand by a psychologist. Furthermore, on a rotational basis, once every two weeks, a psychologist is mandated to hear the cases of several people who registered on the enrolment chart. P-10 also recounted that even though these meetings are once every two weeks, but they start at 8:30am and can stop 4pm. It is full of people that placed their name to benefit from it.

- Ref_11: TR-Func (specialized-service meetings)

  P-10 identified another resource called 'la rencontre de deuxième niveau'. The psychiatrists come to these meetings to hear our child psychiatry referral requests.

- Ref_12: TR-Func (specialized-service meetings)

  P-10 also explained that there is also a psychologist who accompanies the child psychiatrist to hear the requests, and see if we really have to refer or whether there are other things that we can do to avoid clogging up hospitals in the Hotel Dieu de Sacré-Coeur. In addition to other cases, there are a lot of child psychiatry cases. [we do this to] Avoid bottlenecks and that we did everything before deciding that we will refer to child psychiatry.

- Ref_13: TR-PD; TR-Func (**social workers**)

  On the topic of PD, P-10 expressed that she learned a lot from social workers because they go into the field, they go into homes. They tell us things that they see, including family organization.

  In addition, P-10 explained that the social workers are also trained to know all the other types of resources, which she can use to redirect a young person. They are also aware of all the organizations that exist in Quebec City, and so they are able to offer this service in addition to the CLSC service.

- Ref_14: TR-Motiv

  On the topic of resources that motivate her, P-10 notes that there are several points to [mention]

  P-10 is motivated to work with them [respondent psychiatrist] because when she gets to the point where we wants to present [the case], it means that she herself knows more about what to do with the young person.

  P-10 describes that when she reaches the stage where has tried several things and it hasn't worked. For example, the child/young person is not ready for therapy because he is (mentally) too ill, he is not able to respond to therapy. The prescription medication are missing, the family is not present, there are too many missing elements. And during therapy, they go around in circles and realize, "This is not working."

  So yes, in these P-10 notes that working with child psychiatrists is a nice resource because she knows that when the young person accepts admission (because some people refuse) to the Hôtel-Dieu de Sacré-Coeur. There's a big team waiting for them. There's the doctor, there's the child psychiatrist, there's social workers on site, there's specialized educators on site, so it's really - they put it all together. So it's for sure that when P-10 gets to that stage she is motivated to work with the child psychiatrist.

<u>Burnout Group A: P-14 (Team Demand)</u>

- Ref_1: TD-Org (**role ambiguity**)

P-14 noted that there is a contradiction between the conception of the front-line psychologists by the government and the role of the skills developed by psychologists during their training and job experience. Are they liaison officers? Or are they clinicians? There should be something between the two but the reform has taken us too far in the direction of being a liaison officer.

- Ref_2: TD-Org (**breach of therapeutic space**)

  P-14 then elaborated that the work of a psychologist is very intimate. It requires a protected space – like a bubble – in which a patient is protected from the 'tornado' of everyday life. This protected space allows the patient to take distance from everyday life and figure out what they are going through, so that they can fix it. But if you are caught in a tornado, how can you fix yourself? Instead, you're getting hit by the tornado all the time. The interdisciplinary work keeps you closer to the 'floor' and this can hurt the therapeutic bubble that [the psychologist] is trying to build with the client.

- Ref_3: TD-Org (**lack of role clarity**)

  P-14 thinks that the interdisciplinary work is possible but it should be better defined/organized better compared to the way she did it (possibly fewer meetings & interactions with stakeholders). Otherwise there is an encroachment/invasion and boundaries around professional role becomes blurred. For example P-14 felt that she was the therapist of social workers and parents. P-10 recognizes that there are individual differences and that it could be just her personality but there is something about being a psychologist that people under distress come to. However, psychologists need help too. She felt that in doing interdisciplinary work you can get a little sucked in.

- Ref_4: TD-RL:Org (**not enough clinical psychologists**)

  In terms of resources that are lacking, P-14 pointed out that there is a scarcity of psychologists in the CIUSSS. Consequently, when there is one working on a file, the attitude is such that "okay we have a psychologist, lets make the most of her/him". A similar theme plays out in interdisciplinary work.

- Ref_5: TD-Org (**confusion between the role of psychologist and social worker**) TD-Other (**personal preference and comfort with community-based approach**)

  P-14 reported that in her experience there was a confusion between the role of a psychologist and social worker. Having said that the P recognizes that there are individual differences in personalities and skills among psychologists. For e.g. there are psychologists that are very comfortable with the community-based approach, but the P-14 found this approach to be very difficult b/c it is deeply rooted in the 'daily life'. It is difficult to balance this against the therapeutic work that a psychologist does in a more therapeutic space, especially when you are new.

- Ref_6,7: TD-Org (**unfavorable work conditions/workspace**) --> resource lacking

  P-14 also reported that her workspace was not very conducive to do therapy. It was small, cold and without any windows that she had to share with other psychologists. P-14 didn't feel valued and it seemed unfair that those with more experienced had windows, but she didn't blame them.

- Ref_8: TD-Org (**inadequate human resources**) --> resource lacking; TD-Org **(high workload, time/work pressure, performance demands**)

  Despite everything, P-14 reported she had supervision once a month and felt supported by her colleagues. Also on a more broader-level, P-14 noted that the problem was bigger than inadequate human resources. Everyone had a lot of files and they dealt with the same overflow; plus they were caught up in a hellish cycle of performance. No one stops. They were only 8

psychologists for the entire SW territory of Montreal. With a bigger team and better-defined roles between partners they would have felt less overwhelmed and have more perspective.

- Ref_9: TD-Org (**performance demands**; **work overload**)

  In addition to the work with clients, there was an overflow of all the administrative tasks required by the CIUSSS – it became an implicit performance demand. There was a pressure to take on more workload but it was done with a smile (that is to say there was a lot of humanity).

- Ref_10: TD-Org (competition; **work overload**; **organizational culture**; **interpersonal relations**)

  P-14 acknowledges that even though there was excessive work but it was in an compassionate environment (elsewhere she noted that she knows of other places where there is work overload and an unhealthy work environment). P-14 worked with another senior psychologist that took on more cases (P-14 remarked that this senior psychologist was proud to be a hero of the street) and that raised the bar for P-14, especially when she saw that the senior psychologist took 8 files and she had taken none. Since, P-14 was competitive, she wanted to rise up to the challenge. The senior psychologist was 'caught in a wheel' and had already complained to manager because she was under the impression that she had more files than P-14. P-14 also recounts that when she was on sick leave, the senior psychologist added her on FB to ask when she would return to work. So there was compassion but it was in a context in which everyone was overwhelmed with work

- Ref_11: TD-Org (**organizational climate**)

  P doesn't come right out to say that the climate was bad. Instead, she notes that the climate was pleasant but there was something rotten underneath (i.e. it was difficult to stay sane/healthy given the pressures even though the climate was pleasant).

Burnout Group A: P-14 (Team Resources)

- Ref_1: TR-Func (**guichet d'acces**)

  On the topic of functional resources available to facilitate interdisciplinary teamwork, P-14 explained that there is an organizational unit called guichet d'acces for all the youth mental health teams. This unit is responsible for receiving the requests. P-13 elaborated further that this unit is the first point of contact between a client and a MHP and its very helpful because the guichet will connect the client with either the hospital or child protection services. In this way, there's a little background work done before you even get the file

- Ref_2: TR-Func (**service coordinator**)

  P-14 further explained that the service coordinator is another resource. The person in this role will often have an idea of the file because they are the ones that will sign off. The service coordinator can help with providing information, solving problems and connecting CPs with different partners. P-14 noted that they are little higher up in the hierarchy and therefore have a slightly greater executive power to resolve conflicts. P-14 concludes that in this way, the service coordinator provides real support and even some supervision to healthcare professionals.

- Ref_3: TR-Func (**clinical coordinator, team manager, service director/department director, head of department**)

  Building on the available functional resources, P-14 reported that if there are issues at the inter-institutional level, then these would be addressed by a clinical coordinator (is this role different from service coordinator?) and sometimes even by the service director. This was another set of functional resources that would come to the defense of CPs if there was a conflict. P-14 reported that she witnessed really extreme situations in which the department director accompanied the

team manager all over the territory that her team covered, which included the center-south territory of Montreal. Specifically, she recounted that she saw the head of the department accompany one of the collaborators to see the child psychiatrist at Douglas because there really was a problem. That's why P-14 felt that there was this support at the institutional level to solve problems that were between institutions.

- Ref_4: TR-Func/Motiv (**geographical proximity, personal connection**)

  On the topic of functional resources, P-14 informed that even though Douglas hospital is not associated with her CIUSSS, her team worked with the child psychiatry unit because it is physically closer to Verdun than the Sainte-Justine hospital. Consequently, there was a human to human connection, which the P-14 found to be very interesting. The child psychiatry would come and present the cases that they wanted to send over. Similarly, P-14's team could also go there. In this way, they got to know each other and that motivated her.

- Ref_5: ~~TR-Func~~ TD (**expectation to take on more cases**)

  But at the same time P-14 cautioned that its a double-edge sword, because the more a person knows you, the more expectations they are going to have [and] the more they are going to try to pass on to you.

- Ref_6: TR-Func (**service agreements**)

  On a final note on functional resources, P-14 noted that at the functional level, there were procedures established at a higher level for the stakeholder to supervise and facilitate the links between the institutions.

- Ref_7: TR-Motiv

  On the topic of resources that motivated her,

  P-14 reported that its really the interactions she had with people that motivated her because it stays [with you], especially when you click with your colleagues.

  For example, P-14 loved working with a psycho-educator [that she went] to school with. They worked really well together and P-14 felt supported when working on very difficult cases. She felt part of a team working together to help a young person. P-14 found that to be very motivating especially when the file moved forward.

  P-14 noted that she misses this aspect of interdisciplinary work in her private practice and felt that it was very helpful. [side note: having said that P-14 also mentioned that the professional interactions in interdisciplinary work can be synonymous with demands, as much as with resources especially when interpersonal interactions go well. But even interpersonal interactions that are going well can go south, but it's okay because it's part of life.]

- Ref_8: TR-PD

  On the topic of working in an IDT that stimulate learning & PD, P-14 response didn't answer the question. Instead of sharing how working in an IDT stimulated learning and PD for her, she talked about 'all the factors' that stimulate learning and PD. Specifically, she talked about a psycho-educator who was a stagiere (trainee) doing her PhD in psychology. This young professional was really well-trained and would accompany them [to therapy sessions?] so she could do follow-ups later. P-14 frankly noted that she had been overwhelmed for a year and wanted to leave; and the stagiere helped her by taking some of the load off of her. This excerpt basically tells us that the clinical placement program that contributed to learning and PD (i.e. its having the intended effect).

Working in an interdisciplinary contributes to learning and professional development through interactions with colleagues during monthly supervision and meetings with child-psychiatrist.

But often CPs are so overloaded with work that they don't have the time to take advantage of other learning opportunities that were available outside of structured interactions with colleagues.

- Ref_9: TR-Motiv

  (again not related to available Resources to work in IDT that motivated P-14. More about management support) P-14 noted that she had met with her director and told her: next week I'm going to meet another employer, I can't take it anymore. I want to go private." P-14 had been very honest with her and things calmed down a bit after P-14 met with her. P-14 concluded by noting that there were ways to get temporary relief and support through all of this.

- Ref_10: TR-PD

  On the topic of resources that stimulated learning and PD, P-14 reported a few sources of learning, including monthly supervision and meetings with a child-psychiatrist who came every two weeks. P-14 noted that these occasions could be helpful and that the child-psychiatrist was a source of learning as well. But P-14 expressed that within a completely overloaded schedule, sometimes there is an opportunity to learn or to leave, so one's like, "Oh, I dont have the time," but P-14 thinks it wasn't a lack of support for them, the problem really was work overload.

Appendix C-B

Some Burnout (Group B): P-13 (Team Demand)

P-13: work in adult MH team in Gatineau. What is her team size? (could be linked to uneven participation)

- Ref_1: TD-Org (**difficulties organizing meeting**)

  P-13 reported that in one instance, it took her 3 months to organize a meeting (due to scheduling conflict) with other professionals on the team that were following the same patient.

- Ref_2: TD-Org (**lack of meeting space**)

  In addition to the difficulty with finding the right time, there was no space for them to convene for meetings planned in advance. They are expected to reach out and connect on their own

- Ref_2: TD-Soc (**interpersonal/individual differences**)

  P-13 reported that it is not a given that people will collaborate/establish links. For e.g. Some are easy to work with (they are very open, super nice to work and P-13 knows that if she would call them regarding a file, it will be easy to meet and work together), while others are not. It is variable, so individual difference is a factor as well

- Ref_3,4: TD-Oth (lack of knowledge about the role/contribution of a CPs)

  Psychotherapy is something specific in and of itself and can be abstract for some professionals that are not familiar with it. It can be difficult to explain what we see and what improvements have been made, so that its well understood what psychologists do and what it is that we evaluate to assess client's progress.

- Ref_5,6 : TD-AE (**time-consuming**) -->chal

  P-13 notes that given the challenges in planning interdisciplinary meetings in advance and a lack of understanding among some colleagues about the role of a psychologist, it is important to take more time at the front-end because this extra upfront cost in time pays off later in how the client progresses. However, it is a challenge to do this because planning itself takes more time and coordination (due to conflicting schedules). P-13 notes that for multi-disciplinary meetings, it is more of a challenge.

  Given that some colleagues don't understand what a psychologist's job is and given the challenges in planning interdisciplinary meetings in advance, it is important to take more time at the front-end because this extra upfront cost in time pays off later in how the client progresses. However, it is a challenge to do this because planning itself takes more time and organization (due to conflicting schedules).

- Ref_7:TD-**Chal & Hind**

  Fact that some colleagues don't understand the work of a psychologist, P-13 thinks that its both a challenge and hindrance and sees it as part of her job to manage people and to be well understood. its not an unsurmountable problem.

- Ref_8: TD-RL **(administrative support from team managers)**

  P-13 notes a resource that was lacking was space [both in terms of time and meeting areas] for teams to meet and discuss issues. But this has changed and now there is a mechanism that links primary-care and specialized-services. For example, MHPs from primary care can now present the files that they want to refer to MHPs specialized services. But, P-13 recognizes that – given the size of the CIUSSS – it would be difficult (and not realistic) to coordinate such meetings with other health professionals. However, she also notes that having the management's support in terms of

organizing/coordinating these meetings would be interesting [helpful] because managers have contact with each other.

Some Burnout (Group B): P-13 (Team Resources)

- Ref_1: TR-Func (**workspace**)

  P-13 described office space as a functional resource

- Ref_2: TR-Func (**assessment tests**)

  Elaborating further, P-13 reported that in general they have the necessary material to do the work. At times they may not have some of the specific tests for assessments but they is always a way to borrow them from another team. In other words, they have access to what they need in terms of equipment.

- Ref_3: TR-Func (**communication technologies**)

  In terms of functional resources, P-13 also reported that there are small things that make it easy to communicate. For example, they can easily access the telephone number of a person in the CIUSSS by simply writing their last name. Similarly, they don't need to know the email of the person they are trying to reach. P-13 simply writes their email in the 'To' bar and their email pops up.

- Ref_4: TR-Func (**shared workspace**)

  P-13 made another interesting point about sharing physical space with your colleagues. She noted that when you share the same space such as CLSC, you get to know each other, which makes it easier to talk. The connection is easier between different teams when they are in the same place.

- Ref_5: TR-Motiv

  On the topic of functional resources that motivate her, P-13 noted that it is interesting to do interdisciplinary work because each professional has a complementary approach. For example, if she is doing psychotherapy with a client, and this client has someone else who is helping them take care of things at home because they need more support. P-13 declared 'of course that's motivating' because it is effective in helping the client.

- Ref_6: TR-Motiv

  Adding on, P-13 noted that, she feels less alone when she is working with clients that are severely ill or that are difficult.

- Ref_7: TR-PD

  On the topic of resource that contributes to PD, P-13 noted that working in an interdisciplinary team has an impact on learning. For example, they learn from each other during meetings when they discuss what other health-professionals have done [to treat/help a client]

Some Burnout (Group B): P-15 (Team Demand)

P-15: P works in Rouyn-Noranda (region no. 8; l'Abitibi-Témiscamingue) within youth mental health services. This CISSS network covers a large area. There are no 3rd line services. There is a child psychiatrist but no specialized services in psychiatry for children. They see severe cases but no internal (inpatient) or day (outpatient) unit

- Ref_1: TD-RL:Org (**lack of an interdisciplinary team, inadequate support**)

  P-15 works in primary care, within a local service network with no specialized team to take on severe cases and she is the only MHP working with young people going through severe mental health problems. There is no social worker to work on other challenges that a young person may be going through. P-15 understands that this can happen but is also aware that this is not a common practice, especially when she compares it to what she has experienced elsewhere. P-15 also expressed experiencing professional isolation and sometimes feels discouraged given the severity of the cases. At times, they are forced to keep treating these severe cases because they have reached the limit of what they can do and that there is nothing else that they can offer in terms of service.

- Ref_2 TD-RL (**lack of interdisciplinary work)**

  The biggest challenge that P-15 notes is that there is no interdisciplinary work. From her perspective, it is rare that within her team she will work with another MHP. P-15 sees it as something that she misses [rather than] a challenge

- Ref_3,4,5,7: TD-RL:Org (**inadequate time; lack of access to IDPs/inadequate human resources**): In terms of resources that are lacking, P notes that freeing up time during work-hours to have clinical exchanges with other IDPs (Interdisciplinary professionals) and having more access to work with them would make interdisciplinary work easier. P-15 notes that there is a shortage of Interdisciplinary professionals. For e.g. it would be helpful if they had an occupational or speech therapist on the team. Often there are so few (other MHPs) that all of the responsibilities fall on one person. P-15 shares that the stressful thing about doing assessments is that one must really be comprehensive. For example, if she were in a specialized hospital, this task would be shared among other professionals where everyone does a little bit. If there were more of other professionals on the same file or with whom she could share work with, it would take away some of the pressure. There is a lack of not only specialists but also professionals generally.

<u>Some Burnout (Group B): P-15 (Team Resources)</u>

- Ref_1: TR-Motiv

  In response to aspects of working in an IDT that are motivating, P-15 indicated that that she finds: working towards shared goals, having clinical exchanges with other professionals, and learning from other more experienced colleagues to be super stimulating. In addition to sharing the advantages/benefits, P-15 notes that they share difficult/challenging experiences as well, which is not only empowering and encouraging but also normalizes how they feel about a patient or problem

- Ref_2: TR-PD

  On the aspects of working in an IDT that contribute to L&PD, P-15 reported that working in an IDT encourages team members to self-train among each other. For example, P-15 elaborated that if she is working with a nutritionist on an eating disorder - who knows different aspects of nutrition and eating disorders - the knowledge exchange with the nutritionist would often encourage her to do readings and learn more or give her ideas on what to look for. So, in terms of professional development, P-15 finds that it encourages them to train among themselves in terms of what they can do.

Elaborating further, P-15 feels that on a personal level they are individually doing the work but it is the professional exchange with different people or people with different ways of doing things that sparks the desire to seek out and learn more.

Furthermore, P-15 feels that it is also about respect and there is personal growth when try to adapt to each other and work together despite perceived conflicts or aspects that differentiate us.

Some Burnout (Group B): P-18 (Team Demand)

- Ref_1: TD-Org (**inadequate time for clinical exchanges**)

  P-18 finds it valuable to work with other professionals in an interdisciplinary context, but the challenge is that there isn't a lot of time to discuss issues.

- Ref_2: TD-Org (**patient's lack of access to interdisciplinary services**)

  P-18 makes a very interesting point: if MHPs are expected to work in interdisciplinary teams, then people/public/clients should have access to interdisciplinary services. In P-18's opinion, access to interdisciplinary services is the problem and not the lack of interdisciplinary teamwork.

  For e.g. if a patient is followed by a psychologist on a team, she will not be followed by a social worker or a sexologist from the same team unless she seeks access to a community program like Hope that can help with day to day responsibilities.

  Ref_3: TD-RL: Org (**inadequate time for clinical exchanges; inefficient communication processes/systems**)

  P-18 notes that she meets with the respondent psychiatrist once a month but it can be a challenge if there is an emergency and she would like to have access to information quickly.

  P-18 gives an example of a patient for whom she needed to apply for a limited employment capacity. In this case, she needed to contact the psychiatrist that had conducted the assessment, so she contacted the GP. It took about a week to contact the GP in order to set up an appointment and another two weeks to meet. In such instances, if there was a person who could get her information, it would be been helpful. She shares that at another CLSC in Chateauguay there was a phone line that they could call the psychiatrist for information.

  A better system to contact health professionals would also be helpful. It is a complicated process right now which causes delays and during this period the client is stressed and so she has to deal with that as well.

  In addition more scheduled/planned meetings to co-supervise and discuss cases with a GP and psychiatrist would be helpful as well. It's a big team (~ 20 people) and so when they meet once a month, several people have requests and they are unable to address all of them.

Some Burnout (Group B): P-18 (Team Resources)

- Ref_1: TR-Func (planned meetings; GP; Respondent Psychiatrist)

  On the topic of functional resources available to work in IDT, P-18 reported that they have an interdisciplinary meeting once a month and there is a responding psychiatrist present at this meeting that can refer people to psychiatry or provide information on medication (if needed). They also have a doctor at the CLSC who often comes to this meeting as well and they can help/guide them with these problems as well. P-18 pointed out that when it comes to

pharmacological aspect or the functioning of the [health] system [CPs] are a little helpless [because its not their area of expertise].

- Ref_2: TR-Func (**GP; Respondent Psychiatrist**)

  Elaborating further P-18 notes that [GPs & RP] can also help us understand the challenges that people are going through [in navigating the health system] and why things are done the way they are. P-18 confides that they understand people's frustration about it b/c it's frustrating for them too.

- Ref_3: TR-Func (access to institutional knowledge)

  P-18 points out that in her case interdisciplinary team work is positive because it gives them access to information that they do not necessarily have access to. Plus, P-18 adds that nurses and social workers are also present during these meetings to not only understand the processes of how people are referred but also how they are looked after.

- Ref_4: TR-Func (interdisciplinary teams)

  P-18 concludes by noting that the challenge is not when she works with them, the challenge is when she doesn't work with them

- Ref_5: TR-Func

  Echoing back some of the previous comments, P-18 repeats that she thinks working in an IDT is helpful because they have different perspectives but notes that they don't have a lot of time to discuss issues with other people. [They meet] once a month and there are several people who are presenting. They do consult on the floor when they have questions but for her, she doesn't think that there are challenges associated with working in an interdisciplinary team

- Ref_6: TR-Func (clinical operations advisor)

  On the topic of functional resources available to work in IDT, P-18 talked about the clinical operations advisor and explained: let's say, she needed to talk to someone from the "troubled youth family" who referred a client to her service. In such cases, it would be the clinical operations advisor that can arrange a meeting with them [in order to] discuss the matter so that the transfer can take place and they can all agree on the same objective and intervention plan. She is the person who will organize these meetings. In addition, P-18 noted that when they need to present a file to a responding psychiatrists, they ask the clinical operations advisor [to set up those meeting]. [Basically] she is the one who has the resources to organize these meetings.

- Ref_7: TR-Func (clinical operations advisor)

  (P-18 contd.) or answer our questions, but P-18 clarified that the clinical operations advisor manages a lot of people

- Ref_8: TR-Motiv

  On aspects of working in an IDT that are motivating, P-18 reported that she finds it really helpful and motivating. P-18 elaborated further by noting that everyone has their expertise and perspectives that are completely different. And working in an IDT and talking to her colleagues brings out these diversity of perspectives and tools to work with people

- Ref_9: TR-PD

  On the aspects of working in an interdisciplinary team that contribute to L&PD, P-18 indicated that she is definitely learning new knowledge, which allows her better understand 'the other side of the coin' in the network. P-18 admitted that there is a lack of information between the

primary-care and specialized services that they do not have access to and as a result they feel helpless; [therefore] to have the perspective of doctors and psychiatrists [in order to understand] why [things work the way they do] is helpful.

- P-18 noted that it not only helps her understand and develop, but it also helps her clients [because] she can explain to them why it works like that. In addition, it also helps P-18 gain a systems perspective on the situation and understand how [programs like] social assistance work. P-18 concluded by expressing that working in an IDT helps her to expand her knowledge and improve skills.

Appendix C-C

No Burnout (Group C) : P-8 (Team Demand)

P-8: has been a clinical coordinator for 11 years and currently does not see patients. Talking from the perspective of not quite management but facilitator

- Ref_1: TD-Org (**lack of time; interprofessional communication**)

  P-8 notes that the challenges to work in an interdisciplinary team **include taking necessary time** (builds trust) and **communicating effectively** (avoids misunderstanding)

- Ref_2-3: TR-Func (**communication tools such as intervention/service plan**)

  P-8 helps teams to develop service plans to mitigate the demands of working of multidisciplinary teamwork to overcome silos and avoid miscommunication. [communication tools are functional resources]

- Ref_4: TD-Org (**role ambiguity/lack of role clarity**)

  P notes that often the issue is to understand the mandate of other MHPs according to law (role ambiguity). She states that we can presume to know the work of the social worker at school, [and] we can assume that it will be the work of the educator in a rehabilitation center; but, in fact, the mandate may be different depending on the the context of the law, depending on the age of the user. The knowledge of the mandate of each MHP [is the challenge].

- Ref_5: TD-Org (**time pressure**)

  there is time pressure due to work overload {the reform objectives requires them to take in patients within 30 days, do daily reporting (3 statistics/day), meet clients in person (3 per day). The challenge is time and to know when to stop

No Burnout (Group C): P-8 (Team Resources)

P-8

- Ref_1: TR-Func (**planning & communication tools**)

  P-8 reported that she uses tools that are known in the network such as case plans and individual service plans to facilitate exchanges with service-users and healthcare professionals. P-8 also noted that you have to give yourself/take time during planned meetings to build trust. P-8 mentioned that its part of her job to act as a mediator between service-users and health professionals. Building on P-8 also said that as an information officer her role also includes rallying health professionals around service-user's family

  Previously she noted: TD-Org/RL: time. P notes that right now the issue is time. To take the time necessary to do things properly. P talked about intervention plans, individual service plans, but in her role of supervision it is also about the procedure. In her supervision role, [it is also about taking the time to properly follow] the procedure to guide/support psychologists, social workers or psycho-educator. And [to take the time to properly] facilitate clinical meetings with various professionals to discuss cases, guide certain situations. [The] time is often at stake.

- Ref_2: TR-Func (**clinical coordinator**)

  In her supervision role, [it is also about taking the time to properly follow] the procedure to guide/support psychologists, social workers or psycho-educator. And [to take the time to properly] facilitate clinical meetings with various professionals to discuss cases, guide certain situations.

- Ref_3: TR-PD (**enriching**)

  P-8 disclosed that she found interdisciplinary work to be very stimulating and fruitful. It's an investment in time that pays off. P-8 remarked that when you are working alone on a file, there is a possibility that you ignore other opportunities and get limited in their understanding in terms of what can be offer. P-8 feels that a diversity of perspectives (including, other therapist, nurses, and child psychiatrists) can supplement our own understanding or (alternatively) inform our actions and guide services. P-8 found the working in interdisciplinary team to be very enriching.

- Ref_4: TR-Motiv (**stimulating)**

  There is a lot of pressure but P-8 believes that they have made great progress in terms of working in a network and collaborating with each other. She finds it to be stimulating and motivating

No Burnout (Group C) : P-20 (Team Demand)

P-20: Was hired as PhD student, has been working in CLSC for 5 years, got her license in 2017

- WB-S: Hasn't experienced many challenges and generally has a positive experience working in an interdisciplinary team

- Ref_1: TD-Interpersonal (**diagnostic conflict):**

  sometime there is a diagnostic conflict with a GP but they always get along and work on the same treatment goals (minor Issue). The P perceives its as a challenge because she finds it interesting to discuss it each time and thinks that its normal that they don't always agree. P sees this as more of challenge compared to her interactions with DJP

- Ref_2: TD-Org (**work overload**):

  P also notes that she would like the stakeholders from youth protection services (DJP) to be more involved with the family on a regular basis if she is seeing a young patient. But she also realizes that they are overwhelmed and may not have the same time that she does. Related to that, sometimes there can be a delay, before the youth protection services calls her to discuss a particular file.

- Ref_3: TD-Org (**communication delays)**

  Sometimes it can take a while before the collaborators to call us back when we want to discuss, like, a particular issue. But generally speaking, my experience is very positive. I don't have that many challenges working at the multidisciplinary level.

- Ref_4: TD-Org (**communication delays; engagement expectations, diagnostic conflic**t)

  Elaborating on the challenges, P repeats that there are delays and it takes time before she hears back from her colleagues in youth protection services. She also expects them to be more involved in the follow up and to meet the family more frequently but sometimes that is not the case [i.e. different performance expectations over the level of engagement]. They also disagree on the diagnosis. P underscores that these challenges are pretty rare.

- Ref_5: TD-AE: Org (**communication problems, negative interactions w/ collaborators, emotional demands**)

  P agrees that it requires additional effort on her part when there are delays/problems with communications, and she has difficulties reaching her collaborator. Because she has to go to her boss, who then contacts the boss of this collaborator to find out what is going on. And eventually,

when they meet (because they have to) to diagnose the client, she has to address this issue, which ends up taking more time and energy) [minor Issue].

- Ref_6: TD-Chal (**diagnostic conflict**)

  P perceives disagreements over diagnoses as a challenge because she finds it interesting to discuss it each time and thinks that its normal that they don't always agree. P sees this as more of challenge compared to her interactions with DJP

  The P notes that when it is difficult to reach her collaborators at the DJP, it becomes more of a hindrance. But she clarifies that she has experienced this only a few times. Generally speaking, the collaborators at the DJP are very invested and available.

- Ref_8: TD-RL_Org (**inadequate human resources**)

  In response to resources that are lacking P refers back to her comments about DJP and difficulties in reaching out collaborators; she notes that she is under the impression that the problems are due to lack of human resources. There are too many things to do, so they do what they can but are unable to do it all. It's more a matter of human resources than willingness on their part to be more engaged with a file.

- Ref_9: TD-RL_Org (**access to database**)

  Access to (relevant) primary-care databases - a functional resource - is lacking. For e.g. P works with psychiatry but she doesn't have access to their database, so she has to physically go to the archives to access the notes; plus, she can't bring a file back to her office, so it's a waste of time. Access to front-line and psychiatry databases would be useful and make her life easier.

- Ref_10,11: TD-RL_Org (**Inadequate access to a psychiatrist)**

  Adequate time with a psychiatrist - another functional resource - is lacking. For the most part, the team interacts with the same psychiatrist once a month and since there is no time in her/his schedule to talk about cases outside the meeting, the team really hangs on to them during these meeting. Or they have to wait until the meeting is finished. There is no formal meeting to discuss cases. The P thinks that it would be helpful if the psychiatrists have time in their agenda, where psychologists can make an appointment and talk about issues they have in common.

No Burnout (Group C): P-20 (Team Resources)

P-20

- Ref_1: TR-Func

  On the topic of functional resources available to work in IDT, P-20 reported that her experience is generally very positive.

- Ref_2: TR-Func (**respondent psychiatrist; communication tools**)

  P-20 went on to note the resources that are in place at her work are good. In terms of functional resources, she explained that she works a lot with psychiatry and once a month they have consultation meetings with a psychiatrist. [during these meetings] if she is working with someone that are not physically in her workplace, she can reach them quite easily by email or telephone.

- Ref_3: TR-Func: Pivoting back P-20 noted honestly that they have a lot of ways to work well as a team and that she didn't see anything else that would improve IDT.

(in the previous excerpt, P-20 clarified that what she said about DJP. Her impression is that [the reason they are unable to be more present/engaged with the files] is because they are lacking in resources. P-14 felt that its due to a lack of personnel rather than willingness on their part to be more engaged)

- Ref_4: TR-Func (**shared workplace**)

  Continuing the response on functional resources that enable IDT, P-20 mentioned whats practical is that they work in the same physical location. And so, the people on her team and their offices are close to hers. As a result, they can easily discuss the files they have in common. In addition, P-20 has access to their notes and reports, which also helps at work. Over all, she concluded that its not bad.

- Ref_5: TR-Motiv:

  on the topic of working in an IDT that are motivating, P-20 expressed that she loves working as a team, especially in youth mental health. P-20 thinks its necessary because the child is in a family and its not uncommon for the family to experience difficulty as well. P-20 explained that they have to involve the parents while they are seeing the teenagers too. She cant be the therapist of the family, teenager, and parents. She will often ask for help from social workers who provide a space for parents to help them along the way as well. This way, she sees the young person and when its relevant, they have family meetings. P-20 finds this to be really motivating because things move faster this way. Furthermore, since there is more than one professional on a file, she can share her impressions of the family with her colleagues on the team. Finally, not being alone in managing very complex files have a very positive effect too.

- Ref_6: TR-PD:

  On the topic of working in an IDT that contribute to L&PD, P-20 reported that [clinical] exchanges with colleagues are very formative. For example, when P-20 discusses issues with her colleagues, they bring knowledge or a way of seeing things that she did not perceive [or consider]. Another example, P-20 has colleagues that have specific expertise and when she is working on a file that relates to that expertise, she can go and consult them. This helps her to learn more about different topics and also see how different professionals work. P-20 affirmed that its clear that it helps her in her professional practice and in developing her skills as psychologist. She finds it very helpful to be able to share and see how other professionals work.