ADVANCING COMMUNITY-BASED COLLABORATIVE MENTAL HEALTH CARE THROUGH INTERDISCIPLINARY FAMILY HEALTH TEAMS IN ONTARIO

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ABSTRACT

Collaborative mental health care is a widely advocated model of community-based mental health care delivery. Previous work suggests that several contextual factors, such as the lack of stable funding for non-physician providers, have prevented widespread implementation of this model in Ontario. The introduction of interdisciplinary Family Health Teams (FHTs) as part of Ontario's primary health care renewal strategy presents an opportunity to overcome some of these barriers. This case study of emerging FHTs examines how contextual factors influence the mix of providers and quality of collaborative mental health delivery in FHTs. The findings inform policy-makers of opportunities to further develop community-based collaborative mental health care.

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BACKGROUND

Collaborative mental health care has been widely advocated as an important model of community-based mental health care delivery (Craven & Bland, 2006; Gagné, 2005; Kates & Ackerman, 2002; Kirby & Keon, 2006), yet until recently, there has been limited uptake in Ontario (Mulvale & Bourgeault, 2007). Previous work suggests that difficulty securing stable funding to compensate non-physician providers and lack of physician remuneration for collaborative activities under fee-for-service (FFS) payment plans have been significant barriers to the implementation of collaborative mental health care programs in the province (Mulvale & Bourgeault, 2007).

Primary care reform may help overcome these barriers and facilitate the implementation of collaborative mental health care (Pawlenko, 2005), particularly with the introduction of interdisciplinary Family Health Teams (FHTs) as a key component of Ontario's primary health care renewal strategy. The Ontario Ministry of Health and Long-Term Care (2006) provides FHTs with funding to support the salaries of non-physician providers. In addition, physicians have a choice of three blended payment mechanisms to replace traditional FFS payment: blended capitation, blended salary, or blended complement. In capitation, physicians are paid a standard rate per patient; in a salary model, the physicians are paid an annual salary; and in a complement model, physicians are paid an amount to serve the full complement of patients in a community (typically a rural or remote community). In FHTs, these are blended with FFS incentive payments for providing specific preventive care services or for rostering of new patients (Ontario Ministry of Health and Long-Term Care, 2005).

Since April 2005, 150 Family Health Teams have been established in 112 communities across the province; in the fall of 2007, the government announced its commitment to approve an additional 50 FHTs. A proposal for each FHT is developed by a local team and submitted to the Ministry for approval through a competitive bidding process. This local direction allows teams flexibility in selecting the mix of providers and programs offered to meet the primary health care needs of their patient population. The teams vary in size, structure, scope, and governance (Ontario Ministry of Health and Long-Term Care, 2004).

To date there has been limited feedback about how teams determine which mental health care providers to include and how well those providers have been integrated into the overall functioning of the primary care team. This paper examines the following research question:

> *From the perspective of providers in Family Health Teams in Ontario, how do contextual factors at the global, local, and within-team levels influence the mix of mental health providers and the nature of their collaboration with other members of the primary health care team?*

While this paper focuses solely on mental health and addictions service delivery, the research is part of a broader case study of primary health care delivery in FHTs (Mulvale, 2008).

METHOD

Participating Family Health Teams

Purposive sampling was used to maximize variation among 10 FHTs as outlined in Table 1. The selected teams had to have been offering interdisciplinary care to patients for at least 3 months.[1] Three rural and seven urban FHTs from 6 of the 14 Local Health Integration Networks (LHINs) in Ontario (Table 1) were selected. All 10 FHTs offered mental health counselling to their patients, and three offered the services of a visiting psychiatrist. Eight FHTs reported either having a provider with addictions experience or having a dedicated addictions counsellor. Three were networked FHTs (i.e., FHTs with a central administration and multiple sites for service delivery), and one was located in a homeless shelter.

There was considerable variation in the degree to which the mental health providers were integrated into the primary health care team, as summarized in the last four columns of Table 1. Based on the participants' descriptions of interactions among team members, providers in four of the teams appeared to be operating largely in parallel practice; in two teams, there was a consultative relationship among providers; in two teams, interactions were more collaborative with frequent interactions among providers; and two teams were considered highly collaborative, and featured case conferencing and joint meetings with patients.

Data Collection

The study team approached the physician or administrative lead at each FHT to obtain written permission for the team to participate. The FHT lead also identified providers with at least 3 months' experience in collaborative care to participate in interviews. The study team provided written information about the study to those providers (who were from a variety of professional backgrounds as listed in Table 2), and invited them to take part. Once written consent was obtained, the interviews were carried out by telephone[2] by two members of the study team. A semistructured, open-ended interview guide was used to question respondents about the various contextual factors. The interviews were audiotaped and transcribed by professional transcribers who signed a confidentiality agreement. Respondent names were masked to preserve confidentiality. The research received ethics approval from the McMaster Research Ethics Board.

Table 2 lists the number of interviews that included a mental health component by provider type across the sample. A total of 38 interviews contained extracts that pertained to mental health. Ten interviews were with mental health specialists including six social workers, two mental health workers, one psychologist, and three psychiatrists. One visiting psychiatrist served patients of two different FHTs.

Data Analysis

For this paper, all transcripts and extracted excerpts that pertained to mental health care delivery in the FHTs were reviewed. The extracted mental health elements of the transcripts were coded into

Table 1

Characteristics of Sampled Family Health Teams

Case	Governance	LHIN	Geography	Individual or networked	History of collaboration	Co-located	EMR	Regular, full-team meetings	Case conferencing	Quality of collaboration
1	Provider-led	3	Urban	Individual	Yes	Partially	Yes	Yes	No (plan to)	Consultative
2	Community-led	2	Urban	Individual	Yes	Partially	No	Yes-but do not include FPs	Yes	Collaborative
4	Provider-led	6	Urban	Individual (multisite at present)	No	Partially (have plans to fully co-locate)	Yes	Yes	No	Parallel
5	Provider-led	13	Urban	Individual, multisite	Yes	Partially (non-FP staff are co-located)	Yes, but new and not fully used by FPs)	No	No	Parallel
6	Provider-led	10	Rural	Individual	Yes	Yes	Yes	Yes	Yes	Highly collaborative
7	Provider-led	4	Urban	Networked	No	Yes	Yes, but 3 disconnected systems	No	No (plan to)	Collaborative
8	Provider-led	4	Urban	Networked	Yes	No	Yes	No (plan to)	Yes (not all providers)	Highly collaborative
9	Mixed	3	Rural	Individual	Yes	Yes (except 1 FP)	Yes (being implemented)	Yes	No (plan to)	Consultative
10	Provider-led	10	Urban and rural	Networked	Yes	No	Yes	No (plan to)	No (plan to)	Parallel
11	Provider-led	10	Rural	Individual (multisite)	No	No (plan to at one of the sites)	Yes	No (plan to)	No (plan to)	Parallel

Note. LHIN = Local Health Integration Network. EMR = electronic medical record. FP = family physician.

Table 2
Summary of Interviews by Provider Type

Case	Administrator	Family physician	Nurse practitioner	Registered nurse	Psychiatrist	Social worker	Mental health worker	Psychologist	Total
1	1	1				1			3
2	1	1		1		1			4
4		1	1			1			3
5	1	1	1	1					4
6		1	2		1	1			5
7	1		1			1	1		4
8	1	1		1			1		4
9	1					1			2
10	1	1	1		1			1	5
11	1	1	1		1				4
Total	8	8	7	3	3	6	2	1	38

key themes, using a conceptual framework as a starting point and allowing for additional themes to emerge in the coding process. Two members of the study team individually coded the first five interviews, then met to discuss and refine the codes so that a matching of themes and content was achieved. Remaining interviews were coded separately using the final coding scheme. Only factors that were raised by at least three interview participants were included in the analysis.

The study used a qualitative case study approach. Unlike other qualitative research traditions such as grounded theory and ethnography, which develop theory grounded in the data, qualitative case study research uses a conceptual framework or prior theory to guide data gathering and analysis (Yin, 2003). In doing so, this approach recognizes the contribution of prior knowledge in conducting current research, thoroughly explores the continuing relevance of each contextual factor, and modifies the theory based on the findings (Harrison, 2001).

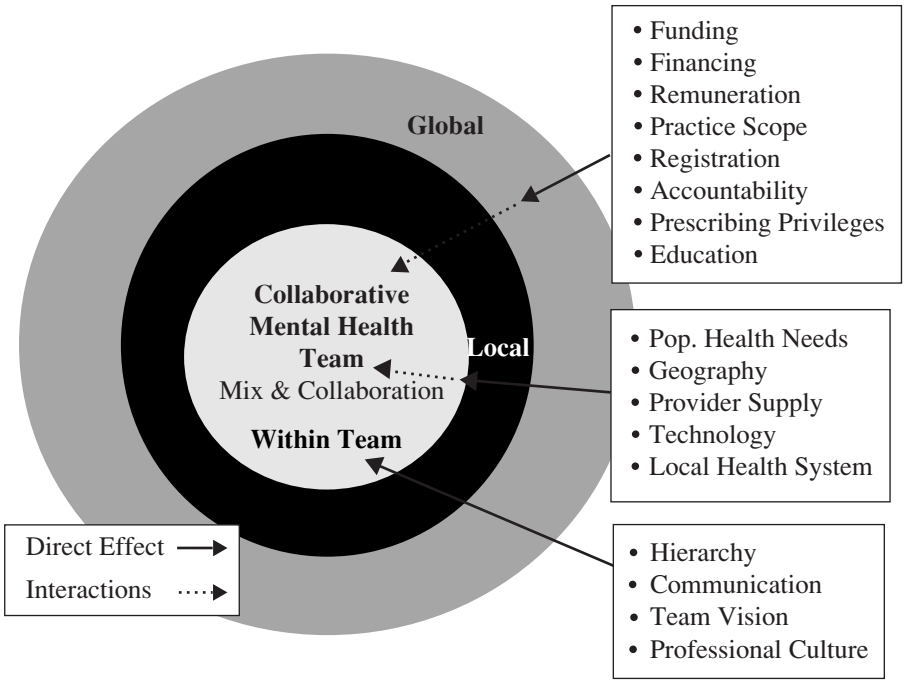
The study team applied the conceptual framework from an earlier study of collaborative mental health care teams that was carried out prior to the introduction of FHTs (Mulvale & Bourgeault, 2007). Many of the factors identified by this framework had also been found to influence the functioning of other interdisciplinary health care teams (Association of Ontario Health Centres, 2007; Boon, Verhoef, O'Hara, & Findlay, 2004; Bosco, 2005; Craven & Bland, 2006; Deber & Baumann, 2005; Gagné, 2005; Hall, 2005; Oandasan et al., 2006; University of Toronto, 2006).

Figure 1 illustrates the framework of contextual factors, and Table 3 defines each factor. The first level, or broadest of the concentric circles, comprises global factors that may affect all collaborative

care programs in the province. These include economic factors such as funding, financing, and remuneration; legal and professional regulatory factors; and the influence of interdisciplinary education. The second level, or middle concentric ring, captures contextual factors that are local to a particular program or population being served, including the characteristics of the population and their health needs, geographic factors, the local supply of providers, and the "fit" of the program within the existing local health care system. The third level (inner circle) includes within-team factors such as the degree of hierarchy among team members, the nature and quality of communication, the influence of differences in professional culture and practice style, and team vision. At all three levels, each of these factors has a direct influence but can also be interrelated in establishing collaborative mental health care.

Figure 1

Conceptual Framework of Contextual Factors Affecting Provider Mix and Quality of Collaboration



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FINDINGS

Many of the contextual factors from the original framework remain important for collaborative mental health care in FHTs. The revised conceptual frameworks of factors affecting the mix of providers and the quality of collaboration are presented in Tables 4 and 5, and in Figures 2 and 3.

Table 3

Definitions of Contextual Factors

Global factors	
Funding	• Stability, level, and nature of funding for interdisciplinary collaborative mental health care delivery
Remuneration	• Variation in how providers are paid within and across disciplines • Remuneration for activities not involving direct patient contact
Financing	• Public insurance coverage for non-physician providers in the private practice primary care setting
Registration	• Education levels required for professional registration by discipline
Practice scope	• Overlapping scopes of practice (these can cause friction among team members but can also allow flexibility in hiring)
Prescription privileges	• Prescribing rights (lack thereof can alienate some providers; e.g., psychologists)
Accountability	• Compatibility of provider insurance across disciplines • Physician comfort with delegating acts to other providers
Education	• Opportunities for/exposure to interdisciplinary team-based learning
Local factors	
Population health needs	• Demographic, cultural, and health needs of the local population
Provider supply	• Availability of mental health providers of different disciplines
Geography	• Distance to travel, and provider shortages in developing teams
Existing local health system	• How team fits within the existing mix of services to meet gaps in service delivery, provide a continuum of care across settings
Technology	• Use of technological infrastructure (e.g., telemental health care) to overcome distance
Within-team factors	
Hierarchy	• Degree to which a traditional hierarchical approach versus a team-based approach where all disciplines are equally valued for their different contributions is present
Professional cultures	• Degree to which differences in professional cultures and practice styles are recognized and respected
Team vision	• Extent to which there is a clearly defined team vision
Communication	• Formal and informal methods of communication among team members (e.g., hallway consultations, team meetings, education sessions)

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Table 4

Factors Affecting the Mix of Providers

	Family Health Teams (cases)									
Factors	1	2	4	5	6	7	8	9	10	11
Global										
Funding		*			*		*		*	
Remuneration	*	*			*		*			
Practice scope	*	*			*			*		
Research	*	*				*		*		
Local										
Population health needs		*	*		*			*	*	
Provider supply						*	*		*	
Geography					*			*		*
Local health system	*	*		*	*			*	*	
Within-team										
Space	*	*	*			*				*

Table 5

Factors Affecting the Quality of Collaboration

	Family Health Teams (cases)									
Factors	1	2	4	5	6	7	8	9	10	11
Global										
Remuneration				*	*			*	*	*
Practice scope	*				*			*		*
Accountability	*			*	*				*	
Within-team										
Communication										
- electronic medical record	*	*	*		*	*				
- team meetings		*	*		*	*	*	*		*
Degree of hierarchy		*	*		*	*	*		*	
Team vision		*			*				*	*
Professional culture/practice style		*			*			*		*
Space		*	*		*	*				
Co-location		*	*					*	*	*

Figure 2

Revised Conceptual Framework of Factors Influencing Provider Mix

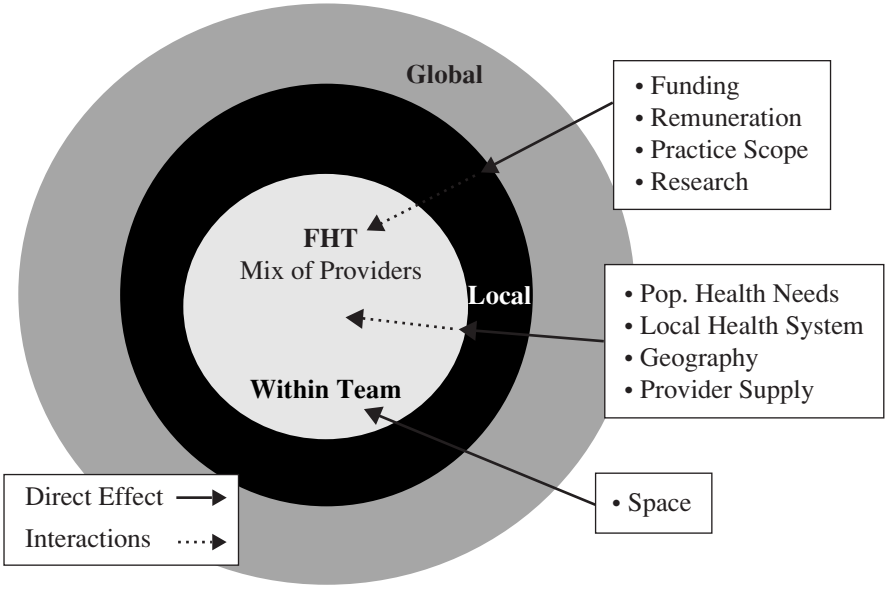
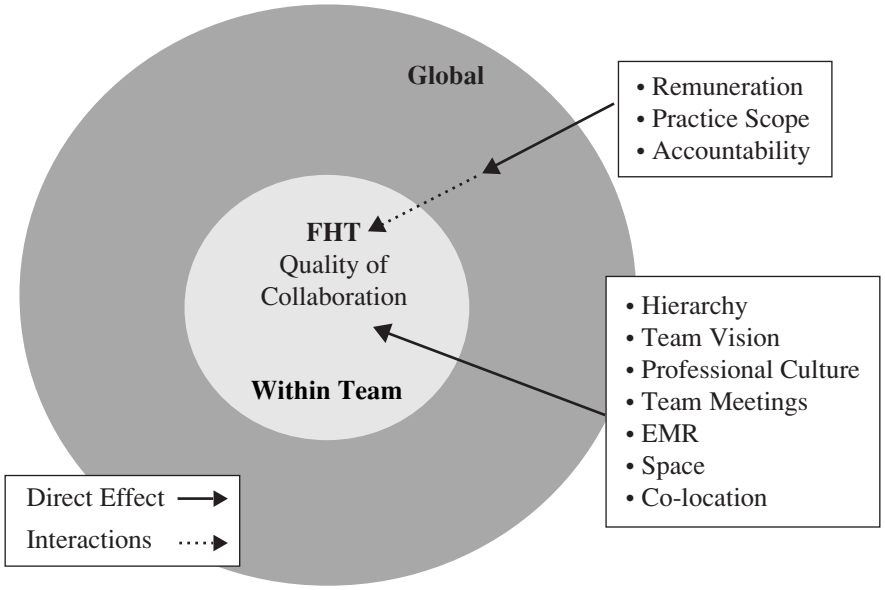


Figure 3

Revised Conceptual Framework of Factors Influencing Quality of Collaboration



Factors Affecting Mix of Mental Health Providers

Global-level factors

Funding. The FHT funding for additional providers enabled teams to include mental health providers. All teams included mental health counsellors (nurses, social workers, psychologists, or mental health workers), but only a minority included psychiatrists. One family physician commented that "in the past the barriers were that the resources just weren't there and [the difference now is] that they're prepared to pay a psychiatrist on sessional time to come into the office" (6-Pr-FP).

The level of funding offered by the Ministry determined the number of full-time equivalent positions for each provider type. One team chose to use their funding for several social workers, each with their own area of specialization: "The funding is for two FTE social workers. What we've done in developing this model is that the two FTEs are actually shared by five social workers" (1-Pr-SW).

Remuneration. The salary benchmarks for non-physician providers made it difficult to recruit some provider types. While social workers, psychologists, and other mental health care workers seemed satisfied with their remuneration, nurses and youth mental health workers considered the salary levels, benefits, and job security offered by FHTs to be low compared with the hospital setting. In some cases, providers worked part-time in the FHT while maintaining more secure employment and benefits elsewhere.

> [It has] been a challenge . . . within our community right now recruiting people to leave the hospital system or a place where they've been fairly established. . . . A number of child and youth mental health professionals who work in the school system as social workers or work in some other area of child and youth mental health have expressed an interest in being able to do part-time work. And that's how we're sort of putting it together in bits and pieces. (7-Pr-YMHW)

Remuneration by blended capitation enabled physicians to participate in consultative and collaborative activities that would not be reimbursed under traditional FFS payment. In the homeless shelter, however, physician remuneration was a stumbling block to establishing the FHT because patients were difficult to roster and had complex care needs for which standard capitation rates were too low.

> The Family Health Team funding is derived in part by the size of your roster. And the size of our roster is very, very small. . . . I told the Minister of Health this scenario. I said that this model really doesn't work that way because these are the "undesirable" rosterable patients. . . . If these people were so easily rosterable, then they might have been able to roster with another doctor out in the community. (2-Pr-MD)

Practice scope. Overlapping scopes of practice offered flexibility in recruiting providers and allowed the FHTs to tailor providers' strengths to specific patient needs.

> There [needs to be] balance between role clarity and role flexibility and letting roles evolve. So you need the flexibility to let it evolve and to recognize that there's overlap and that maybe within the mental health team, there's five different people that could be the lead or counsellor for a particular patient and you're going to . . . select the person that seems most appropriate for that individual. (6-Pr-MD)

Research. Participation in research demonstration projects provided funding to include additional providers in the team. For example, the FHT that was being established in the homeless shelter was

initially funded through the Primary Health Care Transition Fund. Another team was participating in a pilot study to examine the potential role of child and youth mental health workers to provide counselling within the FHTs.

Local-level factors

Population health needs. All teams completed needs assessments to support their initial funding applications to the Ministry. In all teams, mental health counselling was identified as a very high priority. As one social worker observed,

> I think we know physicians are seeing a lot of anxiety, depression. Those tend to be the main mental health issues they're seeing in primary care. Physicians often try to manage those medications on their own, trying to find treatment for their patients with often lengthy wait lists in the community. . . . Across the board . . . it's felt to be a real gap and that's why all the Family Health Teams that I'm aware of are integrating a mental health component. (1-Pr-SW)

Family Health Teams monitored changing population health needs through community advisory boards and electronic medical record systems, using this data to support funding requests for additional human resources: "So we're able to do searches of populations. . . . And from that, we're gathering information on . . . what the client needs are, and where is the greatest need . . . what things are identifiable as being a priority to address right now" (9-RN-Team).

Perhaps the best example of an FHT tailored to the specific mental health needs of a population was the one being established in a homeless shelter. This population often has high rates of mental illness and addictions issues. Individuals are often disengaged from society, making it difficult for them to receive care in traditional settings.

> Now often, again, because these are people who find it very difficult to trust, to engage, they may come and see us and say, well, I'm looking for housing. And that might be it for the first visit. Second visit, you learn a little more. You learn that they want to establish, they want to reconnect with their kids. They have legal matters. They have an addiction. So while we're trying to source programs and apply problem solving, we do counselling. We do some cognitive work with them. We try to teach them applied problem solving. We direct them to more ongoing counselling, whether it be anger management programs in the community, addiction programs, meetings, or just supportive counselling on an ongoing basis. So it's really geared to the individual. So we do a mixture of crisis intervention, many therapeutic interventions, supportive counselling, applied problem solving, referral. (2-Pr-Admin/SW)

Provider supply. Most FHTs are having difficulty recruiting for some mental health positions, particularly psychiatrists and psychiatric nurses, because of local shortages in these specialities.

> The hardest one is getting . . . a psychiatric nurse. (10-Pr-Psychologist)

> Where we do have a gap would be for patients that require psychiatric consultation or input, where the physician needs some support in terms of medication management; we're not able to provide that. (1-PR-SW)

Another challenge is finding qualified individuals with the maturity and self-confidence necessary to work in the primary care setting.

> You've got to be mature enough professionally to take care of yourself. (6-Pr-SW)

> I think that the roles that we're expecting the . . . counsellors to take on . . . [require] someone who has a fair breadth of experience, has a certain level of confidence. We need someone who can work independently because part of the child and youth mental health role is . . . the mentoring and support within the family practice. So it requires a certain . . . level of expertise. (7-Pr-YMHW)

Geography. Recruiting health providers is even more challenging in rural areas (Bosco, 2005). One option is to cover the commuting costs of providers.

> [Place] is economically depressed [so it's] really hard to recruit there. There's not a lot to offer people in their off-hours. . . . To live there is a really tough thing. . . . I commuted an hour every day back and forth. . . . It's for sure a barrier in rural communities. . . . I might have stayed if there had been a travel allowance, an annual travel allowance. (6-Pr-NP2)

In addition, there is often a narrower range of community mental health services available in rural communities. One social worker indicated that no Assertive Community Treatment (ACT) teams were available in the community despite the need. This means that providers must have the ability to deal with complex cases without the supports that may be found in urban centres. However, it can be difficult to find providers who are willing and able to do so.

> [Place] is kind of geographically isolated. And the psych nurses who are here have almost entirely worked in inpatient. And the ones who are working in outpatients are very few. . . . When we were advertising for nurses . . . we got no psychiatric nurses applying who had the skill set that we were interested in at all. (10-Pr-Psychologist)

Perhaps because of these recruitment challenges, FHTs in rural areas emphasize working with existing services and not duplicating them. As one registered nurse commented, "we work in conjunction with whatever services are out in the community. Like, we're not going to reinvent the wheel. . . . We want to work in collaboration" (9-RN-Team).

Local health system. Most FHTs have developed linkages with community mental health services such as ACT teams, crisis supports, the mental health ward at the hospital, and community care access centres. The services and mix of mental health providers in the team are tailored to a particular niche within the local health system. For example, one team that serves a high-needs population, with high rates of poverty and large numbers of elderly individuals, arranged to bring providers of outpatient mental health services on-site to deliver their services at the FHT offices.

> It's really economically depressed there and so you see all those social determinants of health in play. . . . So there was also a significant amount of mental health clients that needed this kind of care. And we were really struggling to get them in anywhere. . . . You can't get them into a team in another city, or you could get them in but they didn't have transportation to get there. . . . So this team came out and it was amazing. We just saw all these "problem" patients get help and get fixed up and they got diagnosed properly or their medications were changed or optimized and we just didn't have the crises that we used to have. (6-Pr-FP)

Many FHTs forged linkages with community agencies by offering joint education sessions for staff. Eventually, these connections developed into joint case conferencing for patients with complex mental health needs who used the services of both the FHT and the various agencies.

> And we meet every month . . . as a group to discuss cases and learn together. . . . They're not specifically part of the Family Health Team or the mental health team, but we certainly connect a lot with those people and we refer back and forth so connecting with those agencies has been really important. (6-Pr-Psychiatrist)

The result is a much broader community planning process that goes beyond thinking about an individual patient to thinking about offering care to the whole community. This kind of community-wide service planning then influences the services and providers required in the Family Health Team.

Within-team factors

Space. Concern about the size and appropriateness of the physical facility where mental health services were being offered was a new factor raised during the interviews. In some settings, the space was too small to allow for collaborative interactions or too clinical for counselling.

> When I'm upstairs, I'm in an examination room, which is inappropriate for counselling in child and youth mental health. I mean you've got a table with stirrups, it's not—it's very clinical. (7-Pr-MHW)

Several participants also mentioned that delays in approvals for space expansion had an adverse impact on their ability to hire appropriate providers for the team: "Space is a big issue. . . . So for them to bring on more health care providers right now, I think would be very challenging" (4-Pr-SW).

Factors Affecting Quality of Collaboration

Global-level factors

Remuneration. Moving from fee-for-service to blended capitation payment was seen as an important enabler not just of collaboration but of developing a more patient-centred approach to mental health care.

> Being non-fee-for-service—that's a huge factor because the intermediate assessment visit is not sufficient to pay for complex care. . . . [With FFS] you need to get them in and out in a hurry and deal with those complex problems through multiple visits so that you can get adequately paid. . . . In patient-oriented care, patients come in with a problem and then you deal with three or four other things usually. . . . We think if there's a whole bunch of problems then you have to really look at them together because they're often interrelated . . . [and this] really makes more sense because how can you deal with those problems piecemeal? (6-Pr-FP)

In contrast, the family physician in the homeless shelter team was still being paid FFS, which seemed to hamper participation in collaborative activities. For example, the family physician focused on direct patient care and did not participate in the weekly meetings of the social workers, nurses, and the chaplain.

> They're so busy when I'm there. They book so many people for me to see that I'm concentrating on seeing the people, looking after their medical issues. And I rarely meet, other than the nurses. I never see the psychiatrist or the psychiatric team, and I rarely see the social workers. It's all through the files. . . . That's the way we have to do it. There's no time to meet otherwise. (2-Pr-FP)

Practice scope. Having an understanding of the scope of practice and the roles of other providers on the team is also critical to effective collaboration. Each provider must be very clear about his or her own scope of practice, especially if patients question what is done by another member of the team.

> I'm very conscious of my scope of practice . . . so I consult wherever I need to. . . . I don't ever make recommendations around medications. . . . I have some people come in and say, "I don't want to be on this anti-anxiety [medication]—I don't think I need to be on it," and I always say to them, "You need to know . . . what your doctor's treatment goals are and . . . Do you need some help figuring out what questions you need to ask to know why?" (9-Pr-SW)

Once roles are fully understood, there is greater respect for what each team member has to offer, which benefits not just patients but all members of the team.

> If we truly understand what social workers and others can contribute to the lives of clients and their recovery, then we're more apt to be respectful of that contribution and want to make sure that we think about it [and] include it where it's necessary. (6-Pr SW)

Accountability. All members of the team understood the family physician to be the provider with the most responsibility for the patient's health. Most teams had mechanisms to ensure that referrals and all information flowed through the family physician. For example, one psychiatrist refrained from writing prescriptions to ensure that the family physician was "kept in the loop," knew what was recommended, and was able to write prescription repeats and make subsequent dose adjustments.

> As far as I understand, the family doctors are still the most responsible person and we are . . . in some respects, a consultant to the family doctor. So the referrals, even if they come through the nurse practitioner, are basically the family doctor's referrals and it's the family doctor's patient. Our role is to take over some of that care, to share some of the care, and to give advice. (10-Pr-Psychologist)

Within-team factors

Communication. Electronic medical records (EMRs) and messaging systems were extremely helpful and widely used by the Family Health Teams. Providers liked having instant access to information from other providers involved in the patient's care.

> You're able to talk to the people who made the referral really quickly . . . and you can review the chart because not every referral letter has got all the information in it that you'd want. And I'm used to working in a hospital where the referrals would come from the community and you wouldn't know very much about the client at all. This is much better. (10-Pr-Psychologist)

> It's wonderful because we can now all access the notes that we all write whereas before I did not have access to the charts . . . I got just a little referral note. . . . Now I can access the patient's [whole] chart. (4-Pr-MHW)

Communication through team meetings varied widely among the various FHTs. Some teams did not have regularly scheduled meetings. The teams with case conferencing were generally those that demonstrated the most interaction and collaboration between the mental health workers and the rest of the team.

> So we each have a folder and we go around and talk about new cases that we're seeing, and we update about old cases, and it's a time for people to ask advice from other people about particular cases. . . . You know occasionally somebody will say "I'm just overwhelmed" and need to moan, and so we may just need to kind of support each other and I think that's part of it as well. (6-Pr-Psychologist)

Professional culture/practice style. Differences in practice style between physicians and other providers are still being worked out. It can be difficult for physicians who are used to working in a self-employed capacity to switch to a more collaborative practice style.

> So, understanding how each person fits into it, and I think it's fairly new and it's a different way of thinking for doctors. . . . You walk in as a social worker and you're used to this whole collaborative approach to things, whereas they're self-employed. It's billable hours—it's just a completely different way of doing it. . . . I don't think people are opposed to it; it's just learning curves for everyone. (9-Pr-SW)

It will also take time for some providers to shift to a more client-driven care model.

> I worked very much with family-driven or client-driven . . . and that's very different for all kinds of professionals to think that you need to include the family or the individual on the team . . . that they have a voice in all of this, and without their voice we can talk until the cows come home and nothing will change. (9-Pr-SW)

In some FHTs there is also differential buy-in to the model by physicians. Some are keen to collaborate, while others prefer more traditional approaches of referring to specialists without a lot of active involvement on the part of the family physician. In one FHT, this issue was a threat to the functioning of the collaborative mental health team. One administrator commented, "We're wasting weeks and weeks with the peripheral physicians . . . who maybe didn't buy in as strongly as the physician leadership did, who aren't tangibly . . . seeing this thing unfold" (11-Pr-Admin).

Hierarchy. All agreed that a critical first condition for open communication is to have a non-hierarchical and non-judgmental relationship among disciplines. In a few FHTs, there was some hierarchy because of the leadership role of physicians in establishing the teams.

> In terms of direction, I don't feel we had a lot of say in that. . . . But I think as pieces of the puzzle, certainly mental health—we need to have a bit of a voice in that. . . . We can be heard . . . individually. In terms of the meetings, there's less time and most decisions get made by management. (7-Pr-SW)

In other teams, hierarchy was not a problem and non-physician providers were helping to set meeting agendas, and suggesting and implementing new programs. Most providers expected that their acceptance by physicians and their role within the FHT would evolve over time.

> I've never seen a flatter hierarchy in my life. (10-Pr-Psychologist)

> I certainly have an opportunity to raise any concerns. And again, if I had any problems, I wouldn't hesitate to, at that time, immediately go and talk to whichever doctor I needed to talk to. They've always been very open to us raising any concerns. (4-Pr-MHW)

Team vision. Having a clearly defined team vision seemed to be helpful to collaboration. One team saw collaboration as a living process, another focused on total patient care, and a third emphasized working together to accomplish health care on a larger scale.

> It's more a process than . . . an actual thing. . . . It's a different way of thinking about providing care. . . . It used to be a client would come in, and you could have service providers side by side. So you might have a nurse practitioner in the practice and a social worker, so they go in one door and they get the nurse practitioner's care, and they go to their GP in another door—and then that's not collaborative care. Collaborative care is definitely a living kind of process whereby those providers are actually collaborating and communicating to the benefit of that person. (6-Pr-SW)

> The whole collaborative care method and model really trickles down to everything, so that people are working together and we're not independent islands doing our own job. We all work together to accomplish health care in a larger scale. (8-Pr-Admin)

Space. The layout of the physical space is also important as a way to facilitate collaboration. The ideal space is the opposite of a traditional physician practice.

> The design of space is something that needs to be taken into account that promotes collaboration. You don't want long hallways with examining rooms where, between clinical encounters, the physicians and other providers are not accessible. You know, it's having things designed around a central work station where people are bumping into each other between patients [that] promotes collaborative work. (6-Pr-FP)

In one FHT, there is not enough physical space to accommodate the mental health team, which is currently located in the local hospital. This arrangement reduces the visibility of the mental health team and lessens the number of opportunities for mutual learning.

> I'm hoping in the first year we will get some of the space stuff ironed out . . . and start getting into their offices more. . . . [Counsellor name] had a much more difficult time . . . being visible, and trying to get people to understand what she does, and she feels underused sometimes there. (11-Pr-Psychiatrist)

Co-location. Almost all participants felt co-location to be very important, a factor that has also been identified in the literature (Craven & Bland, 2006). Benefits include the opportunity to clarify questions and referrals and to do hallway consultations for patients with mental health issues.

> You can clarify what the question or the concern of the family physician is right away . . . before you see the person. And then you provide immediate feedback to the family physician on what you've found and what the recommendations are. So I feel incredibly supported that they know what you're thinking from that. And they also know you're going to be around to support them too, and . . . they can check back in if something's working or not working. (10-Pr-Psychiatrist)

> The psychiatrist has her office just across the hall. . . . I mean, that's the beauty of this whole thing. And if I go into one of the clinics and there's a question, I can raise it with both the nurse and the physician on the spot. (10-Pr-Psychologist)

Without co-location of mental health providers with the rest of the team, the situation is comparable to having a separate mental health clinic. There is less opportunity to take a more holistic approach, which includes the perspectives of all the different non-physician providers on the team.

> I don't particularly want to sort of have a displaced mental health clinic, you know. I don't think it works as well, and I don't think patients get as good care when the family doctors aren't involved. . . . I don't think [it would be as] satisfying for myself or good teaching for the residents. (11-Pr-Psychiatrist)

> The pharmacist is next door to me . . . and he brings a perspective on the medications that wouldn't be within my scope . . . so it adds to the client's knowledge and to my work in that I can see the impact of medications . . . outside of just mental health medications. . . . People don't exist in neat little boxes with just their emotions and their mental health sitting in one spot of their body and . . . physical health sitting in another spot. . . . It's [all] part of what's happening to them. (9-Pr-SW)

POLICY IMPLICATIONS

The findings suggest policy considerations to facilitate the inclusion of mental health providers in Family Health Teams and to promote greater integration with the rest of the team. While the findings are specific to Ontario, they may provide insight for policy-makers and providers in other provinces with similar mandates (Macfarlane, 2005).

The findings indicate that funding, remuneration, practice scope, and research are global-level factors that influence the mix of providers on the team. Population health needs, provider supply, geographic factors, and the context of the local health team play a role at the local level. Having adequate space to accommodate providers from different disciplines was one within-team factor important for recruitment.

These findings suggest that policy-makers should consider the following:

- ensuring that the remuneration of mental health professionals reflects the professional experience and maturity that providers suggest is a prerequisite to functioning well in an interdisciplinary primary health care environment;
- examining the availability of mental health professionals across regions and fostering the development of human resources in mental health that are in short supply;
- remunerating providers who are reluctant to relocate to rural areas for their commuting costs;
- providing additional funding for research to establish the benefits of inclusion of various mental health providers in teams; and
- examining ways to expedite approval processes for capital expansion and human resources in FHTs to facilitate the hiring of mental health professionals.

The findings also indicate that remuneration, practice scope, and accountability at the global level influence the quality of collaboration within the team. At the within-team level, several factors were found to promote more integrated care provision: communication through an electronic medical record and regular team meetings, having a team vision, the absence of hierarchy between the mental health specialists and the rest of the team, and understanding and respecting differences in professional culture and practice style. New factors cited included adequate and appropriate space and co-locating the mental health providers with the rest of the primary care team.

These findings suggest that policy-makers may want to offer educational forums to teach interdisciplinary primary care teams how to enhance collaboration with mental health providers. Topics might include

- the potential roles of mental health providers in primary care teams and their scopes of practice;
- guidelines for frequency and content of team meetings, especially how and when to use case conferencing for patients with complex care needs;
- how to develop a strong vision for collaboration;
- the benefits of using the electronic medical record for collaboration, and practical “how to” tips to help teams transition from paper to electronic records;
- guidelines for space allocation and sample office layouts designed to promote interaction among providers and to offer appropriate spaces for mental health counselling; and
- how to recognize, acknowledge, and work with differences in provider cultures and practice styles.

Overall, Family Health Teams are an important means of providing community-based collaborative mental health care in the primary care setting in Ontario. Similar opportunities may arise through

interdisciplinary primary care initiatives in other provinces. Attention to the identified contextual factors will facilitate the development of future collaborative mental health care teams in the primary care setting and promote a greater degree of integration between mental health providers and other providers in these teams.

NOTES

1. Note that one team, which operated in a homeless shelter setting, had yet to officially become an FHT but was already operating as an interdisciplinary team. It was included because it provided additional insight into the influence of contextual factors (as the physician was being paid by fee-for-service remuneration), and it offered care in a unique setting. Note that in the larger case study, two additional cases (case 3 and case 12) were included. These cases had yet to begin operating as interdisciplinary Family Health Teams and so were not included here.
2. There was one exception: Interviews with the FHT located in a homeless shelter setting were carried out in person.

RÉSUMÉ

Les soins concertés de santé mentale sont un mécanisme de prestation de soins de santé mentale grandement recommandé. Les travaux effectués par le passé montrent que plusieurs facteurs contextuels, telle l'absence de financement stable pour les prestataires de soins qui ne sont pas des médecins, ont nuit au bon développement des programmes en Ontario. Dans le cadre de la stratégie de réorganisation des soins de santé primaires de l'Ontario, la mise sur pied d'équipes Santé familiale interdisciplinaires permet d'offrir des soins concertés de santé mentale dans plusieurs collectivités. L'étude de cas des nouvelles équipes Santé familiale permet de déterminer le rôle des facteurs contextuels dans la diversité des prestataires et la qualité des soins concertés de santé mentale. Les résultats de l'étude permettent d'informer les décideur(e)s des possibilités concernant l'implantation dans la collectivité de soins concertés de santé mentale.

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