

Primary Mental Health Care in the Family Health Team Setting: Tracking Patient Care from Referral to Outcome

Kristina Cordeiro
The Hospital for Sick Children

Mirisse Foroughe
KinderCare Pediatrics

Tessie Mastorakos
Ryerson University

ABSTRACT

This study reports on the mental health services provided at a large, multi-site Ontario family health team (FHT) across one year of service delivery, describing a unique model of collaboration between psychology, social work, and primary care medicine. Patient satisfaction ratings and clinical outcomes were examined pre- and post-treatment. Referral patterns, presenting concerns, wait times, and treatment services are also reported. Significant positive outcomes were observed and patient satisfaction was very high. Importantly, short wait times ($m = 6.4$ weeks) were found relative to traditional mental health settings.

Keywords: primary care medicine, collaborative care, mental health care, family health teams, clinical outcomes

RÉSUMÉ

Cette étude traite des services en santé mentale fournis par une équipe de santé familiale de l'Ontario dans plusieurs établissements sur une période d'un an et présente un modèle unique de collaboration entre la psychologie, le travail social et la médecine de premier recours. Le niveau de satisfaction des patients et patientes et les résultats cliniques ont été évalués avant et après les traitements. Les pratiques en matière d'orientation, les problèmes initiaux, les délais d'attente et les traitements ont également été analysés. Des

Kristina Cordeiro, the Hospital for Sick Children, Toronto, Ontario; Mirisse Foroughe, KinderCare Pediatrics, Toronto, Ontario; Tessie Mastorakos, Ryerson University, Toronto, Ontario.

Correspondence concerning this article should be addressed to Kristina Cordeiro at 31 Edinborough Crt., York, Ontario, M6N 2E9. Email: kristinacordeiro@gmail.com

résultats positifs significatifs ont été observés et la satisfaction des patients et patientes a été très élevée. D'abord et avant tout, les délais d'attente sont courts ($m = 6,4$ semaines) comparativement aux environnements de santé mentale traditionnels.

Mots clés : médecine de premier recours, soins en collaboration, services de santé mentale, équipes de santé familiale, résultats cliniques

Primary care physicians are often the first point of contact for patients experiencing psychosocial and emotional difficulties. Amongst people with a diagnosable mental health condition, only a third meet with a mental health professional, although 68% will visit with their family physician (Gunn & Blount, 2009; Miranda, Hohnmann, & Attikisson, 1994). This statistic underscores a much-lamented reality: access to primary health care generally excludes mental health (Astin, Goddard, & Forys, 2005; Geist, Weinstein, Walker, & Campo, 2008; Lesser, 2000).

Primary care physicians undoubtedly hold an important role in the early identification and treatment of mental health difficulties. A substantial number of primary care visits (25–40%) are directly related to mental health (Anssea et al., 2004; Chomienne et al., 2011; Gunn & Blount, 2009) and many of the physical ailments presenting in primary care (e.g., cardiovascular disease, obesity) are inextricably tied to psychosocial and emotional factors. However, primary care physicians are limited by time constraints, and often report feeling ill-equipped to fully address mental health needs in their practice, while faced with delays or barriers in linking individuals in need with outpatient services (Craven, Cohen, Campbell, Williams, & Kates, 1997; Gunn & Blount, 2009; McDaniel & deGruy, 2014; Nash, McKay, Vogel, & Masters, 2012; Swenson et al., 2008). The challenges of treating mental health difficulties within the busy medical practice setting have been acknowledged previously (Astin et al., 2005; Azrin, 2014; Hooper, 2014; Petterson, Miller, Payne-Murphy, & Phillips, 2014; Vickers et al., 2013).

Over the last two decades, health care systems have begun developing interdisciplinary healthcare models that encompass both physical and psychological health (McDaniel & deGruy, 2014), adopting a biopsychosocial approach to health promotion and disease management (Gatchel, Oordt, & Gatchel, 2003; McDaniel & deGruy, 2014). Countries around the world have begun to integrate mental health care into multidisciplinary “shared care” teams, attempting to “bridge the gaps” of otherwise disjointed healthcare services (Fischer, Heinrich, Davis, Peek, & Lucas, 1997). In Canada, Ontario’s family health teams (FHTs) combine the efforts of family physicians and interdisciplinary healthcare providers (IHPs), such as nurse practitioners, social workers, psychiatrists, dietitians, and other healthcare professionals, working collaboratively to coordinate the best possible care for patients. Having a range of healthcare services available in one location is convenient for patients and facilitates communication between IHPs (Craven & Bland, 2002; Gask, Sibbald, & Creed, 1997). Moreover, the family practice is familiar to the public, which may reduce stigmatization (Chomienne et al., 2011) and lead to a greater willingness to meet with a mental health practitioner recommended by, and known to, the family physician (Rock & Cooper, 2000).

Integrating mental healthcare providers within primary care settings presents an opportunity to reduce the economic impact of mental illness and relieve the burden on primary care physicians. Indeed, mental

health needs have been tied to frequent and prolonged emergency department visits (Chang, Weiss, Orav, & Rauch, 2014) and may underlie a large number of primary care appointments (Adam, Brandenburg, Bremer, & Nordstrom, 2010; Simon, 1992; Tessler, Mechanic, & Dimond, 1976). Integrated mental health services not only offer efficient access to effective care (Chomienne et al., 2011; Goldberg, Jackson, Gater, Campbell, & Jennett, 1996; Kates, Crustolo, Farrar, & Nikolaou, 2002; Ray-Sannerud et al., 2012; van Orden, Hoffman, Haffmans, Spinhoven, & Hoencamp, 2009) and increased provider support (Kates, Craven, Crustolo, Nikolaou, & Allen, 1997; Kates, 2008) and satisfaction (Kates et al., 2002; van Orden et al., 2009), but may also decrease the number of referrals made to outpatient clinics (Goldberg et al., 1996; Goossen, Staley, & Pearson, 2008; Kates et al., 2002) and the number of emergency room visits (Doey, Hines, Myslik, Leavey, & Seabrook, 2008). Integrated settings have also been linked to high levels of patient satisfaction (Goldberg et al., 1996; Goossen et al., 2008; Kates, 2008). Researchers have suggested that the combination of early intervention, prevention, and improved interprofessional communication may be positively impacting patient experiences (Farrar, Kates, Crustolo, & Nikolaou, 2001; Goossen et al., 2008).

Preliminary evidence also suggests that integrated settings have shorter wait times for mental health services compared to traditional settings (Goldberg et al., 1996; Haggarty, Jarva, Cernovsky, Karioja, & Martin, 2012). This is important because outpatient agencies providing mental health services within Ontario have reported waiting periods of more than one year for clinical assessment and treatment services (e.g., The Hincks-Dellcrest Centre Annual Report 2013–2014). Moreover, children requiring psycho-educational assessments often wait one to three years on wait lists at schools within the Greater Toronto Area and surrounding cities (see also School–Community Connections, 2012).

Rationale and Purpose

While there is increasing emphasis on interprofessional collaboration, and preliminary evidence supports the provision of mental health services within primary care, there remains a paucity of research reporting on the mental health services provided within FHTs. Responding to the call for studies of the mental health services delivered in Ontario's new primary care settings (e.g., Bryan et al., 2012; Petterson et al., 2014; Pollard et al., 2014; Stancin & Perrin, 2014; Vickers et al., 2013), this exploratory study examined the psychology and social work services provided over the course of 12 months at a large multi-site FHT. To the best of our knowledge, only one group has reported on patient outcomes within a FHT setting, the Hamilton FHT Mental Health Program (e.g., Kates, Craven, Crustolo, Nikolaou, & Allen, 1997; Kates, 2008), which included registered nurses and social workers providing counselling, as well as psychiatrists providing brief consultation to patients and indirect services, such as medication reviews and case consultation. As such, the inclusion of both child and family psychology and social work in the present study provides a unique contribution to the current state of knowledge, and allows for an examination of a complete range of mental health services, including assessment, counselling, diagnosis, and formal treatment for children, adults, and families.

Integrated social workers within FHTs offer services for a large number of patients with mild to moderate mental health difficulties, providing counselling and skills training, as well as supporting individuals with accessing community resources. Rock and Cooper (2000) demonstrated that integrating social work

services within primary care resulted in reduced depression, anxiety, and adjustment difficulties, and led to fewer physicians' visits. Although the value of social work services within family medicine has been discussed elsewhere (e.g., Firth, Dyer, Marsden, Savage, & Mohamad, 2004; Ni Raghallaigh, Allen, Cunniffe, & Quin, 2013) there is little research examining social work services within FHTs.

To our knowledge, previous studies of primary mental health care have not reported on the role of psychologists and psychological services within the FHT model. However, preliminary evidence from a demonstration study within family medicine practice suggests that integrated psychological services are associated with improved patient-reported quality of life, high satisfaction ratings from patients and physicians, as well as reductions in doctors' mental health billing (Chomienne et al., 2011). Physicians reported that having a psychologist on-site "freed up their time and provided opportunity for earlier diagnosis and access to appropriate, effective, and timely psychological interventions" (Chomienne et al., 2011, p. 286).

As highly trained, autonomous mental health specialists, psychologists assess, diagnose, and treat a wide range of mental health difficulties using empirically supported interventions. Functioning in the full scope of their practice, their role can include triage (e.g., screening for clinical disorders, determining the level of care required, and making referrals), collaboration with existing mental healthcare clinicians and other IHPs, development, implementation, and evaluation of programs and services for the most common mental health needs within the FHT as well as secondary prevention programs (e.g., parenting workshops, healthy eating and body image groups for teens at risk etc.), and consultation with families, schools, hospitals, and child welfare agencies (Nash et al., 2012).

While there are 200 FHTs currently operating across Ontario, providing care for over 3 million people (Ontario Ministry of Health and Long Term Care, 2014), only 10% of these settings currently employ a psychologist, most of whom work in a 0.2–0.5 FTE position (just 1 to 2.5 days per week) and have had to narrow their scope of practice accordingly. As the first Ontario FHT to integrate a full-time clinical psychologist, and the only FHT in Ontario to currently employ a full-time child and family psychologist, this study reports on a unique model of collaboration between psychology, social work, primary care medicine, and the allied health professions at the Summerville Family Health Team (SFHT). Information about referral concerns, wait times, and service delivery are presented along with patient satisfaction and outcome information.

METHOD

Setting and Population

Summerville Family Health Team is a large FHT comprising five treatment sites serving over 50,000 patients who reside primarily within the Peel, Etobicoke, and Halton regions of Ontario, Canada. At the time of data collection, each of the five FHT sites was staffed with a registered social worker (Master's level). One clinical child and family psychologist provided services to youth and families across all of the five sites. The FHT had sought a child and family psychologist in order to provide diagnostic services, as well as to complement the areas of practice covered by the social workers.

SFHT social workers provided individual counselling for adolescents and adults, as well as couples therapy. Patients meeting any of the following criteria were directed to psychology: (1) 12 years of age and younger, (2) family therapy or parent-child referrals, (3) patients with complex needs (i.e., greater symptom severity or less common symptoms), and (4) patients requiring diagnostic assessment or formal treatment. The psychologist's role was multi-faceted, emphasizing direct patient care with individual clinical assessment and diagnostic services, specialized and empirically supported individual and group treatment for children and adolescents, parent-child dyadic therapy, and family therapy. The role of the psychologist also extended to consultation with other IHPs, physicians, residents, and medical students training at the FHT, chronic disease management program development, and teaching/supervision of psychological interns as well as medical students opting for a mental health rotation.

Multiple group programs were developed in response to patient need, increasing efficiency and maximizing resources. For instance, a large volume of referrals for school anxiety led to the development of an Anxiety Treatment Group for school-aged children by the psychologist, absorbing the associated referrals from the wait-list, as well as providing open access to other FHT patients through self-referral or referral from physicians/IHPs. Another example is the Inter-Disciplinary Eating Disorders Treatment Team, which provided comprehensive treatment for patients with a diagnosed eating disorder and included medical monitoring (by the family physician), ongoing guidance on nutrition and physical growth (provided by the dietician), parent support and/or couples counselling (by the social worker) and family-based treatment as well as individual therapy for the child/adolescent (provided by the psychologist).

While the model of care was brief, and patients requiring intensive and long-term services were referred out, mental health care was provided for a wide range of difficulties and severities. After the second year of the full-time psychology program at SFHT, the only patients referred out for mental health services were patients able to access private services or requiring highly specialized care (e.g., psychotic symptoms, moderate to severe autism, brain injury, and gender identity concerns).

SFHT's mental health program received 956 referrals between January 1, 2011 and December 31, 2011 inclusive. These were patients rostered with a SFHT physician, and referred internally to a mental health practitioner by an IHP or by patients themselves whenever a patient or family would benefit from such services. Information was collected regarding 635 patients referred to mental health services at four of the five SFHT sites throughout 2011, of which 96 were referred for child and family psychological services. Descriptive statistics are summarized in Table 1. There were no significant demographic differences among social work patients among the four sites.

Procedure and Data Collection

Information was collected directly from patients and indirectly through chart reviews using SFHT's electronic medical records (EMR). Information regarding patient functioning and treatment outcome, as well as patient satisfaction with the services, was collected from patient self-reports, completed by a subset of patients after informed consent was obtained. All other information (e.g., demographics, referral patterns and concerns, wait times, and service utilization) was retrieved from patients' EMR, de-identified, and analyzed in aggregate.

Table 1
Age and Gender of SFHT Mental Health Referrals in 2011

Demographic	All Sites <i>N</i> = 635	Social Work <i>N</i> = 539	Psychology <i>N</i> = 96
Age			
Mean	35.24	39.79	10.4
SD	18.32	16.11	4.32
Range	85	80	16
Minimum	2	7	2
Maximum	87	87	18
Gender			
Female (%)	65	68.50	45.80
Male (%)	35	31.50	54.20

Measures

Data were collected regarding referral source (e.g., physician or self-referral) and the presenting concerns identified at the time of referral (i.e., the reason(s) mental health services were recommended). Wait time was determined by calculating the amount of time between the date a referral was made and the first in-person session scheduled and held with a mental health practitioner. Occasionally, patients were provided the name and contact information of a social worker by the referring IHP and asked to contact him/her directly. In such cases, the referral date reported was the date the IHP instructed the patient to contact the social worker. New referrals to psychology were always made directly by the referring IHP to the psychologist. Patients who had already received services from the psychologist or a social worker were able to self-refer at a later date if needed.

As a measure of treatment length, the number of sessions attended by patients with their mental health provider was noted. Additionally, information regarding the specific services provided (e.g., psychoeducational assessments, cognitive behavioural therapy, supportive counselling etc.) and service modalities used (e.g., individual, group, or family approaches) was collected.

Pre- and post-treatment ratings on the *Outcome Rating Scales* (Outcome Rating Scale [ORS]; Miller & Duncan, 2000; and Child Outcome Rating Scale [CORS]; Duncan, Miller, & Sparks, 2003a) were used as patient-reported measures of treatment outcome. The ORS scales are visual analog scales that assess well-being and functioning across 4 domains (individual, relational, social, and overall functioning). Patients 7 to 12 years of age were administered the CORS, which measures the same 4 domains as the ORS, though they are labelled differently for ease of understanding with younger patients. Hash marks are placed along

4 lines nearest the pole that best describes a patient's functioning within the domain indicated; marks nearer the left of the line indicate poorer functioning and marks to the right represent higher ratings. Scores are determined by measuring where each mark lies along the 10 centimetre lines using a ruler, adding up to a score out of 40. Scores of 25 or below denote significant distress and are considered a clinical "cut-off." Psychometric evaluations of the ORS demonstrate high internal consistency (Campbell & Hemsley, 2009), moderate test-retest reliability, and indicate that the measure is sensitive to changes resulting from treatment (Miller, Duncan, Brown, Sparks, & Claud, 2003).

Pre- and post-treatment ratings on the *Session Rating Scales* (SRS; Miller, Duncan, & Johnson, 2002; and CSRS; Duncan, Miller, & Sparks, 2003b) were used to evaluate participants' satisfaction with therapy and their perceptions of the therapeutic alliance. Session satisfaction and therapeutic alliance are rated along four domains (relationship and respect, goals and topics, approach or method, and overall effectiveness), which are renamed for ease of understanding in the CSRS, administered to patients between 7 and 12 years of age. Administration and scoring for the SRS is identical to that of the ORS described above. Scores of 34 or below indicate a poor alliance. The SRS has been shown to have high internal consistency with a Cronbach alpha of .88, and moderate test-retest reliability (Campbell & Hemsley, 2009; Duncan et al., 2003).

Data Analysis

Data analysis included descriptive and frequency statistics. To assess wait times, the time lapsed in days from the date of referral to patients' first session with a mental health service provider was calculated. To evaluate patients' satisfaction with their therapy sessions and therapeutic alliance, a repeated measures analysis of variance (ANOVA) was conducted examining changes in SRS scores over time. In order to assess treatment outcomes, a repeated measures analysis of variance ANOVA was conducted examining changes in ORS scores over time. Significance levels were set to $p < .05$.

RESULTS

Referral Patterns

Frequency analyses indicated that physicians accounted for 85.71% of the referrals made in 2011, while 3.05% of patients self-referred. Other top referring IHPs included nurse practitioners (4.50%), social workers (2.41%) and the psychologist (2.09%). A similar referral pattern emerged when examining referrals to psychology alone, with 84.38% of referrals coming from physicians, 6.25% from social workers, and 4.17% from nurse practitioners, while self-referrals accounted for only 1.04%.

Information regarding reasons for referral was available for 633 patients. Referring IHPs identified more than one presenting problem at the time of referral for 35.55% of patients. The reasons for referral to social work and psychology are reported in Table 2.

Table 2
Reasons for Referral to Social Work and Psychology

Social Work (<i>N</i> = 537)		Psychology (<i>N</i> = 96)	
	%		%
Depression	29.98	Behaviour	39.58
Relationship Difficulties	22.91	Anxiety	25.00
Anxiety	20.67	Intra-familial Stress/trauma	20.83
Intra-familial Stress/trauma	17.69	Depression	16.67
Co-morbid Anxiety and Depression	15.27	Learning/Developmental Delay	16.67
Work Related Stress	12.66	School Related Stress	8.33
Grief	7.26	Body Image and/or Eating Disorders	6.25
Addictions	3.17	Grief	4.17
School Related Stress	2.42	Co-morbid Anxiety and Depression	3.13
Body Image and/or Eating Disorders	1.68	Addictions	1.04
Behaviour	1.49	Relationship Difficulties	1.04
Learning/Developmental Delay	0.56	Work Related Stress	0.00

Note. More than one presenting concern could be identified at the time of referral.

Wait Times

Twenty-seven patients were excluded from the wait time analysis, 16 due to missing information and 11 who were identified as outliers in a preliminary analysis. Outliers were defined as patients for whom the mental health practitioner was unable to contact (for example, if their phone number was not in service) and whose wait time fell 3 standard deviations or more from the mean. Four hundred and seventy-eight patients were included in the final analysis of wait time. The overall wait time to see a mental health provider at SFHT was 6.41 weeks on average ($SD = 5.43$). The wait time to see a social worker was 5.80 weeks ($SD = 5.14$) and the wait time to see the psychologist was 10.64 weeks ($SD = 5.48$).

Service Delivery and Utilization

During 2011, 505 newly referred patients (79.53% of referrals) received services from a SFHT mental health professional. The reasons patients did not utilize mental health services were not formally collected; however, because mental health services were available across five treatment sites, geographical inconvenience was not likely a reason for missed sessions. The most common psychological services for youth and families were family assessments (79.03%), cognitive behaviour therapy (CBT; 22.58%), consultations (16.13%), diagnostic assessments (12.90%) and dyadic therapy (12.90%). Other services included emotion-focused therapy (EFT), referrals, family-based therapy (FBT), counselling, brief therapy, and psycho-educational

assessments. Fifty-five percent of psychology patients received individual therapy sessions and 42.11% took part in parent-child therapy sessions. The most frequently provided services for social work patients were counselling (87.56%) and CBT (10.18%). Other services provided by social workers included brief therapy, consult services, and referrals. Most social work patients received individual therapy sessions (96.15%), while 5.43% were involved in couple's therapy.

Treatment Length

Thirty-six percent of patients who received services from a mental health IHP attended a single session. Often, patients who attended only one session did so because the therapist and client collaboratively decided that further treatment was not necessary at that time or because a referral to other services was more appropriate. In psychology alone, 90% of patients offered a service at the FHT returned for that service, while the remaining 10% were not ready for treatment (i.e., motivation, readiness for change, timing/circumstances etc.), though many returned after 2–14 months and proceeded with treatment. This data was not available for social work. The average number of sessions for all patients receiving mental health services at SFHT was 3.24 ($SD = 4.41$). Specifically, patients receiving psychological treatment had on average 4.21 sessions ($SD = 2$), with the maximum number of sessions attended by any one patient being 28. However, not all psychology patients were recommended a treatment following their initial intake session (i.e., the first session), and after removing these patients from the analysis, the average number of sessions increased to 7.48 for psychology. Patients attending therapy sessions with a social worker had an average of 3.08 sessions ($SD = 3.99$), with the maximum number of sessions attended by any one patient seen by a social worker being 37.

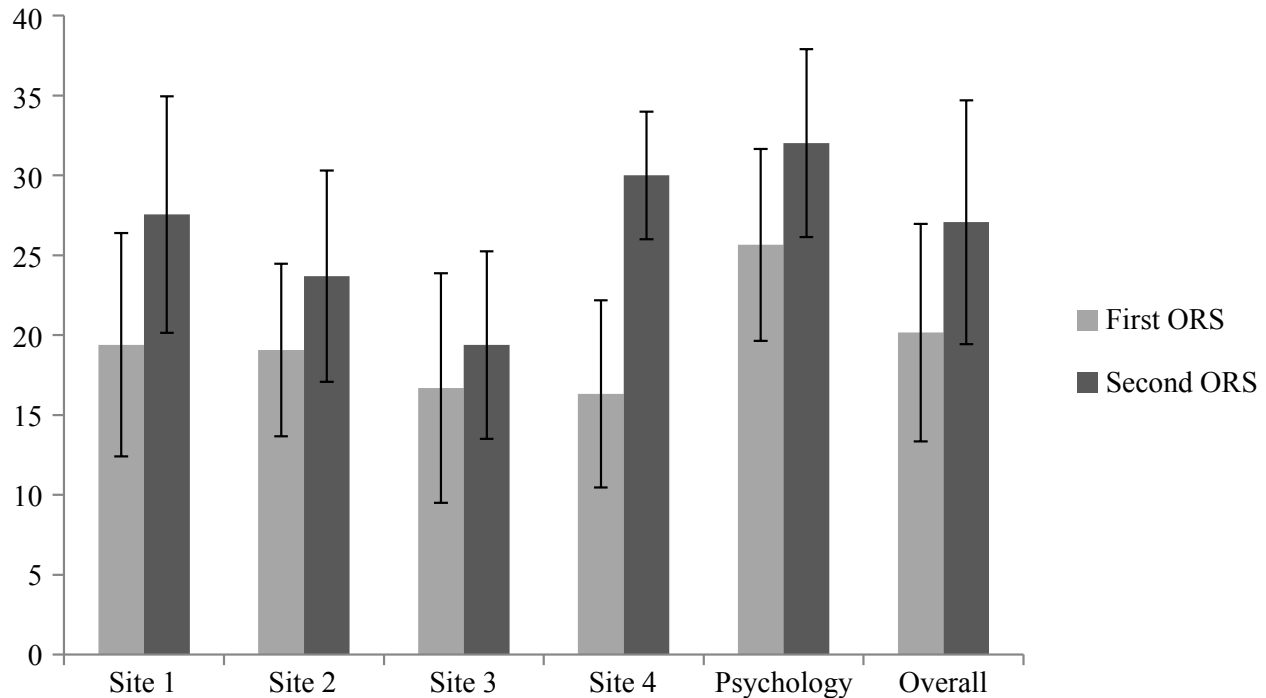
Patient Satisfaction

Pre-treatment SRS scores were available for 127 SFHT patients across two of the four SFHT sites examined in the study, including the patients of two social workers and the child and adolescent psychologist ($M = 35.34$, $SD = 5.10$). Only patients who had pre- and post-treatment ratings available were included in the analysis of patient satisfaction. Results show there was no significant change in SRS scores between the first ($M = 35.14$, $SD = 4.52$) and the last ($M = 36.10$, $SD = 4.60$) obtained SRS scores, $F(1,68) = 1.92$, $p = .17$. Patient satisfaction was high both at the start of treatment and at the end of treatment, with only 10.42% of patients providing a rating of less than 30 at the start of therapy and 7.78% at the end. Session one SRS ratings for those patients who attended a single session were comparable to those who had more than one session ($M = 35.51$, $SD = 5.91$); $t(125) = 0.33$, $p = .74$.

Treatment Outcome

The ORS was completed by 162 patients, however only those who attended more than one therapy session were included in the analysis of treatment outcome. Results revealed a significant change between the first ($M = 20.16$, $SD = 6.80$) and last ($M = 27.07$, $SD = 7.63$) obtained ORS scores, $F(1,90) = 57.43$, $p < .001$. Specifically, 82.4% of patients reported improved levels of functioning and well-being at the end of therapy, indicating that the services provided were effective in helping patients. The results are summarized in Figure 1. Additional correlational analyses found no relationships between changes in ORS scores and patient age, reasons for referral, wait time, treatment length, treatment modality, or treatment service.

Figure 1
A Summary of the Mean Scores for the First and Last Obtained ORS Ratings at SFHT



Note. Standard deviations are represented in the figure by the error bars attached to each column.

DISCUSSION

Reporting on 12 months of mental health services at Ontario's first FHT with a full-time clinical child and family psychologist, this study of the SFHT reports on a unique model of collaboration between psychology, social work, primary care medicine, and allied health. The findings show that integrated mental health care delivered within a primary care setting can provide patients with timely access to mental health triage, effective mental health services, and specialized programming responsive to SFHT's specific needs. Patients who completed self-report measures provided consistently high satisfaction ratings. Our findings suggest that the inclusion of a full-time psychologist at a FHT allows for a wide range of effective mental health programs and services for a variety of common and distressing concerns, including depression and anxiety, complex trauma, social and relationship difficulties, self-esteem issues, stress, and behaviour problems in children, as well as specialized assessment and treatment of clinical disorders.

The vast majority of patients (82.4%) receiving mental health services at SFHT reported significant improvements in well-being and daily functioning, substantiating other studies reporting improvements in

mental health following counselling and support services received through an integrated primary care setting (e.g., Chomienne et al., 2011; Ray-Sannerud et al., 2012; van Orden et al., 2009). The current findings also confirm that there is a clear need for mental health services within primary care; nearly 1,000 individuals/families were referred to the mental health team at SFHT across one year of service delivery alone. Anxiety and depression were the third most common reasons for visits with the family physician, and the top two reasons for physicians' visits (hypertension and heart disease) are understood to be inextricably linked to psychosocial factors that underlie and exacerbate chronic disease. For these and other medical health issues, behavioural and psychological treatments hold great promise as part of comprehensive primary health care.

Shorter waits for mental health services, (average of 6.4 weeks) relative to traditional settings within the community (average of more than one year), was another finding of this study. This is in line with an earlier study (Haggarty et al., 2012). Possible factors contributing to shorter waits within FHTs include accountability (the referring IHP is in direct contact with the service provider), available clinical time (most of the mental health professionals' time is spent on direct patient care, with only 1–2 hours of mandatory staff meetings every three months), efficiency (referrals are sent via EMR directly from the provider, so that there are no administrative delays), and a more restricted catchment (i.e., only patients rostered with a FHT physician). Although the wait time for psychology was higher than that of social work, the FHT psychologist was responsible for patient referrals from across all of the five FHT sites and provided comprehensive psychological assessments and formal treatment programs that often involved information exchange with collateral sources.

Anecdotal reports from the physicians at SFHT indicated that many patients were only willing to access mental health services because they were provided within the FHT; the fact that the providers of these services were on-site and personally known to their primary care physician was highly valued, and patients also appreciated the range of mental health services available within the FHT.

The integration of mental health services within primary care settings is in keeping with the biopsychosocial model (Gatchel, Oordt, & Gatchel, 2003; McDaniel & deGruy, 2014). When mental health difficulties are not identified or go untreated, patients become "frequent users" of primary care services, with repeated complaints and significant psychological distress. The integration of mental health care providers within primary care settings presents an opportunity to improve outcomes for the patient population and relieve the burden and cost on the primary healthcare system as well as in emergency rooms (Doey et al., 2008; McDaniel & deGruy, 2014; Schoen et al., 2011).

Future Directions

One limitation of the present study is the lack of comparison group, such as a traditional mental health-care setting or a wait-list control. Additionally, while previous researchers (Tata, Eagle, & Green, 1996) have reported comparable levels of psychological distress across traditional outpatient settings and primary care settings, future research is needed to evaluate mental health programs in primary care while controlling for illness severity and patient characteristics. It is worth noting, however, that many Ontario FHTs are mandated to service low-income, high-risk patients with multiple diagnoses and high-needs families (Ontario Ministry of Health and Long Term Care, 2013).

Future studies should also track medication use among patients and consider including objective measures of patient functioning, such as outcome ratings obtained from primary care physicians or nurse-practitioners, in addition to self-reported patient outcomes. Similarly, objective measures of service utilization, such as number of primary care or acute care (emergency room) visits before and after commencing treatment with a mental healthcare provider, and the nature of those visits, would provide further information about the potential impact of primary mental health care on overall health and associated service utilization. Preliminary evidence suggests that models of shared care may increase family physicians' comfort in dealing with mental health difficulties and their involvement in treatment (Kates et al., 1997; Kates, George, Crustolo, & Mach, 2008); further research on physicians' and other IHPs' perspectives would be beneficial. Finally, FHTs provide an ideal setting to investigate the impact of ongoing access to primary care on the health and well-being of a given population, including prospective studies to determine if access to mental health services decreases the number of patient visits to the primary care physician, as well as the risk of chronic disease over time.

CONCLUSION

Integrated primary care may be an effective model for efficiently reducing symptoms of mental illness, improving mental health functioning, and maintaining high levels of patient satisfaction. Considering the prevalence of mental illness presenting in primary care, especially anxiety and mood disorders, as well as chronic biomedical conditions which may be amenable to evidence-based psychological practice, integrated primary mental health care is a logical and long-overdue requirement for the provision of efficient health care. With greater access and shorter wait times, primary care clinics such as FHTs play a key role in screening, identification, and early intervention for mental health difficulties. FHTs may serve as an efficient alternative to traditional mental health settings, offering the right care for patients in need, and doing so in the familiarity and accessibility of the family physician's office. The greatest promise of primary mental health care is in the ability to achieve positive outcomes with fewer sessions, within a familiar environment and in close communication with the family physician, keeping wait times relatively short and maximizing access for the target population.

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