Looking for Help: Primary Care Providers' Need for Collaboration to Deliver Primary Mental Healthcare Services

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ABSTRACT

Primary care providers deliver the majority of mental health care to individual Canadians. Researchers suggest that these practitioners are not prepared to deliver these services and require collaboration with mental health specialists to better meet patients' needs. This study describes family physicians' and nurse practitioners' perceptions of the need for consultation and collaboration from mental healthcare specialists. The theme, Looking for Help, is explained by three categories: My Comfort Zone, I Lack the Education, and Not Enough Time. Findings from this study may inform future collaborative mental healthcare initiatives and primary care networks.

Key words: primary care provider, family physician, mental health care, primary care, nurse practitioner, interprofessional collaboration

RÉSUMÉ

La majorité des Canadiens qui ont un problème de santé mentale sont traités par des prestataires de soins de santé primaires. La recherche suggère que ces praticiens ne sont pas bien préparés pour offrir ces services, et qu'il est nécessaire qu'ils aient la collaboration de spécialistes en santé mentale pour mieux répondre aux besoins des patients. Dans cette étude, l'auteure décrit ce que les médecins de famille et les infirmières praticiennes invoquent quand ils parlent de leurs besoins de consultation et de collaboration de

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la part des spécialistes en santé mentale. Le thème principal qui s'en dégage, « Je cherche de l'aide », se décline en trois sous-thèmes : « Ma zone de confort 》,《 Je manque de formation » et《 Je n' ai pas assez de temps ». Les résultats de cette étude peuvent nous aider à mieux comprendre les besoins des prestataires de soins de santé primaires en matière de consultation et collaboration de la part des spécialistes de soins de santé mentale, et fournissent des pistes pour consolider la prestation de soins de santé mentale collaboratifs.

Mots clés : prestataires de soins primaires, médecins de famille, soins de santé mentale, soins primaires, infirmières praticiennes, collaboration interprofessionnelle.

Internationally, primary care providers' (PCPs) role in mental health services delivery is well recognized (World Health Organization [WHO], World Organization of National Colleges [WONCA], 2008). PCPs, including family physicians (FPs) and nurse practitioners (NPs), are integral to Canada's mental health system because they provide the majority of treatment to those who have mental illness (Lesage, Goering, & Lin, 1997; Lin & Goering, 1999; Rhodes, Bethell, & Schultz, 2006). Fleury, Bamvita, Aube, and Tremblay (2010) conducted a survey of 398 general practitioners. Most of these practitioners reported following those with common mental disorders, anxiety, and depression on a continuous basis. Moreover, these practitioners reported that the individuals with common mental disorders typically accessed only a PCP for service.

Researchers report that 12.1% of FPs' practice focus on mental health, the fourth largest reported area of focus (Canadian Medical Association [CMA], College of Family Physicians of Canada [CFPC], & Royal College, 2013). While PCPs do provide the majority of mental health care, there has been some concern about their ability to accurately diagnose mental illness (Kessler, Lloyd, Lewis, & Gray, 1999; Simon & VonKorff, 1995), detect severity (Kroenke, Spitzer, & Williams, 2001), prescribe appropriate medications (Swenson et al., 2009), provide appropriate intensity of treatment and follow-up services (Simon, et al., 1998), and provide counselling services (Goisman, Warshaw, & Keller, 1999; Wang, Langille, & Patten, 2003) within the primary care environment. Furthermore, researchers report PCPs' lack of comfort when treating particular patient groups such as those who express suicidal thoughts and those with complex or multiple issues (Anthony et al., 2010; Henke, Chou, Chanin, Zides, & Scholle, 2008). Finally, FPs have raised concern about the current remuneration model (Henke et al., 2008). Three types of remuneration for FPs are commonly implemented across Canada: (1) fee-for-service (FFS), with an incentive to provide high quality billable services; (2) capitation, where FPs are provided a fixed payment per time period and per patient; and (3) salaries, where FPs receive a fixed payment that is not related to patient volume (Wranik, Hanrahan, & Tarrant, 2012).

The Canadian Mental Health Collaborative calls on mental health providers to collaborate and provide consultations to PCPs to improve timely access to mental health services (Macfarlane, 2005). Today, there are a variety of programs that increase access to mental health services in primary care such as, Collaborative Mental Health Care (Kates, Mazowita, Lemire, Jayabarathan, Bland, Selby et al., 2011), Rapid Access Consultation to Expertise (www.raceconnect.ca), and primary care networks; however, there are few studies that capture the PCPs' need for collaboration.

Wener and Woodgate (2016) present a model that describes how providers proceed through four stages to develop interprofessional collaborative relationships to deliver primary mental health care: looking for

help, initiating co-location, fitting in, and growing reciprocity. Understanding the PCPs' need for consultation and collaboration, the first stage of this model is fundamental to the development of the interprofessional relationship.

Thus, this paper expands on the findings of the first stage of the interprofessional collaborative relationship building model (Wener & Woodgate, 2016) by focusing on PCPs' needs to seek mental healthcare providers' expertise to provide care. In addition to understanding the PCPs' needs, attention is also given to the PCPs' contextual barriers that interfere with relationship development. Findings from this study may inform future development of collaborative mental healthcare practices specifically, and primary care networks more broadly.

METHODS

In the study a grounded theory approach was used to understand the experiences of healthcare providers' interprofessional collaborative relationships (Wener & Woodgate, 2016). Further analysis of the FPs' and NPs' individual interviews was done to explore the PCPs' emergent description of their experiences. The University of Manitoba Research Ethics Board provided ethical approval for this study. Informed consent was obtained from participants prior to the commencement of all individual interviews.

Participants

Recruitment flyers were distributed to all 110 PCPs, 100 FPs and 10 NPs who participated in a primary care, collaborative, mental health program in an urban centre located in central Canada. We sought to recruit providers who varied in age and gender, had a practice site within an urban centre, and the FP remuneration model was either fee-for-service or salaried from the region (SFR). Recruitment continued until data saturation was achieved (Charmaz, 2006).

Data Collection

A participant demographic self-report form was used to collect social demographic information. Between March 2011 and February 2012, the first author (PW) of the study conducted 16 semi-structured 60-minute individual interviews. The interview guide included open-ended questions about the patient population served and PCPs' need for expert consultation. For example, PCPs were asked to describe experiences when patients required mental health services and how comfortable they felt in providing care.

Data Analysis

Descriptive statistics were used to analyze the socio-demographic questionnaires. Individual interviews were digitally audio-recorded and transcribed verbatim. To achieve the goal of understanding the PCP's need for collaboration with mental health specialists, further analysis of the 16 individual interviews was conducted. This analysis was intended to describe the participants' perspective, while maintaining a close relationship to the data (Charmaz, 2006). Memos or analytic write-ups were done for each interview. These memos were read and re-read, comparing one to the other, noting similarities and differences within and

between memos. Preliminary categories, codes, and example quotes from the memos were entered into a coding table, while remaining open to new and emerging codes (Charmaz, 2006). Similar initial categories were collapsed to form the overarching theme and three categories. Interview transcripts and a newsletter describing the preliminary findings were mailed to all study participants for feedback prior to the finalizing of the categories.

Results

Demographics. Sixteen PCPs participated in this study including, 10 (62.5%) females and 6 (37.5%) males who varied in age from 30 to 65 years and who practiced in a variety of primary care clinics within the health region.

Seven (43.75%) of the PCPs participated in the provincial FFS remuneration program and the remainder of FPs were SFR. All NPs receive an annual salary. There were more physicians (n = 11, 68.75%) FFS (n = 7, 43.75%) and SFR (n = 4, 25%), who participated in this study than NPs (n = 5, 37.5%). However, only 10% of eligible FPs participated in this study whereas, 50% of eligible NPs participated in this study. As well, more female PCPs (68.75%) than male PCPs (37.5%) participated in the study. Overall, FFS FPs were older and graduated earlier than both the SFR FPs and the NPs. The SFR FPs tended to be younger than the FFS FPs and NPs.

Qualitative analysis. Participants' quotes are integrated into the findings to illustrate the overall theme and each category, using ellipsis to shorten the quotes while retaining the participants' overall intent. The overarching theme of Looking for Help emerged from the data. As this FP describes, Looking for Help is when the PCPs seek mental health consultation because the patients' needs are beyond the PCPs' knowledge, skills, and comfort:

> …I'm unsure of the diagnosis, or my treatment hasn't worked. It is something other than anxiety and depression …so if I'm really uncomfortable, I'm not sure if I'm missing something else. I consult. … but mostly it's (consultation) for when it's not working. (FP5)

This overall theme is explained by three categories: My Comfort Zone; I Lack the Education; and Not Enough Time. The PCPs describe their experiences when looking for help in the context of wanting to provide patients with care that is consistent with best practices. The categories held true for all participants regardless of their professional background or remuneration model. However, there were some differences between the FPs who had been in practice for more than 20 years and the other FPs and NPs with fewer years of practice.

Category one, My Comfort Zone is about PCPs' self-perceived capacity to deliver mental health care in primary care settings without accessing mental health specialists. Most of the participating PCPs shared their ease working with "straightforward patients" (FP4); that is, those who present with depression or anxiety and who are responsive to medication or counselling.

The PCPs also described that as they gained more primary care experience they developed increasing comfort delivering mental health care to patients with depression and anxiety, "…years ago, I had a lower threshold of comfort with a lot of these things (mental illness)… I think you get better as you pass time…" (FP1). However, PCPs were similarly clear in their expression of discomfort when patients presented with

mental illness, multiple life issues, co-morbidities, were not responsive to treatment, or when there was an unclear diagnosis.

> …diagnostics for sure and complex medications. Actually there's one patient where I just said, like, I'm not comfortable managing him at all. I need you to manage his medications…he was homeless, he had all these legal problems, he had no family in the city, he's got FASD, probably schizophrenia as well, a violent history…. (FP8)

Similarly, this NP described discomfort treating individuals who lack insight:

> …the degree of the mental illness… if they're so clouded with psychosis or OCD tendencies where they haven't got the insight… you're going to have to draw in someone else… another opinion about other ways we can approach this or some stronger medications or... (NP)

Study participants also expressed difficulties working with individuals diagnosed with personality disorders and had often diagnosed them as having depression. The PCPs described their difficulties as a lack of knowledge and skills needed to be able to help patients to move forward with their lives: "I've been treating for depression for years, and they're never really getting better, and you've tried all different medications." (FP4)

Although some PCPs were comfortable managing patients with schizophrenia and bipolar illnesses, most PCPs were very clear in stating that they did not have experience working with people with these diagnoses and that they were uncomfortable offering treatment: "I'm probably not very comfortable with schizophrenia. We don't see enough of it that…I don't have enough knowledge with or I'm just, I'm just not comfortable with and I guess bipolar" (FP2).

Participants perceived a need to engage or collaborate with mental health specialists to increase their level of comfort and to provide a broader range of needed services such as counselling. By collaborating with mental healthcare specialists, PCPs can comfortably offer mental health care to a wider range of patients, including those who may be perceived as difficult. Furthermore as this FP described, collaborating with mental health specialists meant offering counselling sessions to patients who could benefit from this additional healthcare service, "…there's a lot of people who require counselling … that's the nice part of having somebody so you don't have to go looking for a psychologist" (FP15).

Category two, I Lack the Education, is about the PCPs' perceived need for help because their educational background does not prepare them to independently deliver mental health care in primary care settings. While all of the study participants describe being educated to be generalists, there was some sense that their education does not adequately prepare them to provide mental health care. This lack of preparation was particularly true for those study participants who have been in practice for more than 20 years. For example, one FP who has been in practice for over 25 years expressed the opinion that education about mental illness and treatment was not a focus in medical education programs: "… in part, quite honestly, I think in my case the teaching in mental health issue was woefully lacking" (FP16). Although the NPs did not identify an overall lack of attention to mental illness in their educational programs, this NP described the limits of the educational program, "…I mean I've got one person in my practice that I've hung onto but those patients require a higher level of expertise than I'm prepared with in my educational program" (NP11).

Participants recognized their lack of education and skills in specialized approaches such as cognitive behavioural therapy (CBT), although they acknowledge the value of this therapy for the patients: "I'm not trained in cognitive behaviour therapy…there's different techniques and different things that the mental health workers do that is a real valuable add-on to what we have…" (FP2).

While study participants were aware of no-cost evening and weekend educational sessions that are designed to increase their knowledge and skills in providing primary mental health care, PCPs had difficulty attending these sessions. Rather than attending continuing education sessions, the PCPs discussed the value of collaborating with mental health specialists who could provide education that focuses on particular cases, "It's (educational evenings) not a priority for me… I want to know about new medications … what is helpful is being able to sort of talk one-on-one about a specific case (with the mental health specialist), that's helpful…" (FP15).

The participants also discussed learning through their previous experiences and how working through some of the more difficult situations was helpful for future understanding.

> … you remember the things that burnt you in the past, where you actually could have done a better job and realized it, and you're not going to let that fool you the next time. (FP1)

Category three, Not Enough Time, is about the PCPs perception that patients with mental illness want and need counselling that requires more time than the NP or FP can provide. PCPs believed that their practices were driven by time rather than quality. As this physician explains, the perception of lack of time was grounded in the FFS remuneration model where physicians receive a fee for services provided that, in turn, requires physicians to see many patients in a day:

> The big problem with family medicine and psychological problems is that they're time consumers, and unfortunately the way the system is set up, it is time-driven and your remuneration is based on how many patients you see in a day… They punish you for doing a good job and they reward for doing a very quick and superficial job. That's the way it works; it's sad but it's true. (FP1)

Study participants who were remunerated through a SFR model where they receive an annual salary, also found they were not able to provide patient-focused services to their patients with mental illness, especially if the patients want to talk with them or be counselled. This SFR FP explained:

> … they really want to talk to me and to be listened to… as an MD there's some time for that, but not really, not enough time to really do that justice…. (FP6)

Unlike the FPs, NPs in this study provided longer appointments that they perceive as more fitting for the patients with mental illness. "I find those half hour appointment times most appropriate for mental health issues" (NP10). However, although this NP said that the 30-minute appointment was a good fit for patients with mental illness, the same NP explained that time restrictions limit care to providing medications:

> I guess, not unlike physicians, most of my role in mental health revolves around medication, (and) to a smaller extent, you know, counselling, but that's the minor extent of it, 'cause again, like the physicians, my—my time is limited too…. (NP10)

In their attempts to provide patient focused care, providers felt pressure to offer services to their patients with mental illness that were beyond their knowledge and/or time capacity. Study participants believed that getting help from specialists might relieve this pressure.

> I think with the patients what I'd like to devote, in terms of time to them, sometimes doesn't translate into the time we have in a day. Just like we were saying before, you only have a certain number of hours in a day. I'd love to be here 24/7 but unfortunately there's other demands that you get stretched and pulled for as well, and with that I think sometimes you need more specialized care and more specialized help. (FP13)

DISCUSSION

In our study, PCPs discussed providing primary mental health care while at times feeling uncomfortable, ill prepared educationally, and constrained by time to provide optimal care to their patients. The participants in our study described their comfort providing services to those with depression and anxiety that are responsive to treatment, while feeling uncomfortable providing treatment to those with a major mental illness such as bipolar disorder. While Sherman, Gilliland, Speckman, and Freund (2007) reported that PCPs feared being overwhelmed treating those with depression, other authors reported results similar to ours; PCPs mostly treated those with anxiety and depression (Craven et al., 1997). Mitchell et al. (2006) presented the role of FPs in treating schizophrenia and bipolar disorder; however this author did not go beyond a description of study effectiveness. Consistently, the participants in our study described having difficulty diagnosing, and being uncomfortable working with, patients who have a borderline personality disorder. People with this diagnosis are thought to be difficult to treat (Gross et al., 2002).

Some authors have reported that FPs are dissatisfied with the quality of mental health care that they are able to provide (Clatney, Macdonald, & Shah, 2008). Other authors, who have reported results similar to our study, suggested that developing PCP mental health specialist consultative collaboration may alleviate PCP discomfort working with patients who present with complex mental health illness (Fickel et al., 2007). The results of this study may inform where the need for mental health consultation lies. For example, these study participants indicted that comfort develops over time thus, mental health consultation services could focus on FPs within their first five years of employment in primary care. Similarly, more intensive mental health consultation could be aimed at PCPs who serve patients with serious mental disorders, such as schizophrenia and bipolar disorder, or patients with common mental disorders with co-morbidities, and multiple life issues. Less intensive consultation services, such as telephone consultations (www.raceconnect.ca), could serve PCPs with more years of experience or to those who are wanting diagnosis confirmation and suggestions of treatment including medication.

There has been increased attention given to the lack of education FPs receive about mental health. In particular, only 60% of family practice residency program directors were satisfied with the amount of psychiatry education their residents receive (Leigh, Stewart, & Mallios, 2006). NPs reported that although mental health was a primary practice concern, 80% felt they were not equipped to treat mental illness (Elsom, Happell, & Manias, 2005). FPs in Saskatchewan reported that education in mental health care needs to become an area of focus (Clatney et al., 2008). Given that the majority of mental health care is provided by PCPs, further attention to their educational needs is warranted.

Participants in our study preferred education that was specific to their cases and for the most part did not attend formal evening educational sessions. Similar to the findings in our study, the WHO and WONCA recommend that in order to successfully integrate mental health services into primary care, joint consultations between PCPs and specialists is an effective and practical means of education (WHO & WONCA,

2008). However, other researchers have reported that educational strategies, such as case consultations and didactics, did not improve patient outcomes (Lin et al., 1997). Sherman, Gilliland, Speckman, and Freund (2007) implemented an educational program within a newly created primary mental health care collaborative service. These authors suggested that PCPs required education on collaborative care, as well as information focusing on managing mental illness such as depression.

The findings about comfort and education from our study conducted in an urban centre in central Canada are consistent with those studies conducted in eastern Canada (Farrar, Kates, Crustolo, & Nikolaou, 2001; Fleury et al., 2008; Fleury, Bamvita, & Tremblay, 2009; Rockman, Salach, Gotlib, Cord, & Turner, 2004). Similar findings may be due to the consistency in training within the physician and nurse practitioner education programs across the country. For example, the Canadian College of Family Physicians determines the educational and practice requirements for all physicians completing a residency in family practice in Canada (College of Family Physicians of Canada [CFPC], 2015) and the Canadian Nursing Association offers a core competency document that outlines the requirements for all Canadian nurse practitioners (Canadian Nurses Association [CNA], 2010). Furthermore, few NP or FP trainees receive education from mental health experts in primary care settings. Rather, most mental illness training typically occurs in tertiary care facilities where patient presentation and resources available to treat patients are different (Cochrane et al., 2000; Wasylenki et al., 2000).

Time was consistently identified as a barrier to providing primary mental health care and has been reported previously by other researchers (Craven et al., 1997; Henke et al., 2008; Sherman et al., 2007). Henke and colleagues (2008) reported that physicians did not have the same amount of time as counsellors to provide treatment, having just enough time to make a diagnosis and prescribe medication. Similar to other studies, the participants in our study identified a lack of time to provide counselling as the most common constraining issue (Benzer et al., 2012; Fickel et al., 2007; Henke et al., 2008). However, these same authors reported that many FPs in their study routinely put 30 to 60 minutes aside to provide counselling to some patients.

Anthony et al. (2010) found that one-third of their PCP study participants did not consider the patients' emotional problems because of perceived time limitations. When an FP suspects that a patient may be experiencing psychosocial problems, some FPs consider the time constraints when deciding whether or not to question patients about their mental health. Participants in other studies perceived time constraints to be due to patient volume, whereas the participants in this study thought that the remuneration model was the barrier, rewarding those who spend less time with their patients. As described above, there are three different types of FP remuneration are commonly implemented across Canada: (1) FFS with an incentive to provide high quality billable services; (2) capitation, where FPs are provided a fixed payment per time period and per patient; and (3) salaries, where FPs receive a fixed payment that is not related to patient volume (Wranik, Hanrahan, & Tarrant, 2012). In the current study it was only the FPs, in their discussions with study investigators, who said that remuneration was a barrier to working with individuals with mental illness. However, in the context of collaborative care, authors of a recent study concluded, "when patients were attached to a team of providers and funded on a per patient basis, shared care and collaboration were encouraged" (Wranik, Korchagina, Edwards, Bower, Levy, & Katz, 2015, p. 33). Time constraints and remuneration models must be considered as health authorities begin to create primary care networks.

Limitations

This study included FPs and NPs who were already participating in a collaborative care or shared mental health program and may represent a particular group of PCPs. Furthermore, the participants in this study may have perceived that they would benefit; i.e., receive even more access to mental health specialists if they described issues that may be attended to within a consultative collaborative mental health care service. The purpose of qualitative description is to provide results that are grounded in the participants' experiences. As only 10% of FPs participating in the collaborative program participated in this study, the findings must be interpreted with caution and cannot be generalized to other FPs participating in the collaborative mental health program. Furthermore, PCPs in this same urban centre who did not have access to mental health specialists may or may not be looking for help for reasons other than a lack of comfort, education, and time. This study focused on one type of collaborative mental health care where counsellors and psychiatrists offer consultative services while co-located. It should also be noted that there are many types of collaborative mental health care that include other professionals, such as psychologists and occupational therapists, who deliver mental health services. However, at the time of this study other collaborative care programs were not available to the PCPs in the study location.

To provide a broader perspective regarding the PCPs' need to deliver mental health care in primary care settings, future studies should gather data from mental health experts to understand how they contribute to collaborative mental health care. This qualitative study reflects the findings of these study participants in this particular urban centre. However, as other Canadian researchers have reported similar findings, future work in this area may focus on developing pre-licensure educational interventions to increase NPs and FP residents' comfort, knowledge, and skills of mental illness. In addition to focusing on education, the study findings may inform primary care network development by highlighting the importance of understanding the PCPs' consultation needs and current barriers, including length of appointment times and remuneration models. If primary care networks are to be successful, consultations must fit the PCPs' needs and barriers to consultation must be removed.

CONCLUSION

The participants in this study described the issues that prompted their need for help in order to provide optimal primary mental health care. Many of the PCPs expressed their need for help to increase their comfort, knowledge, and experience to provide high quality primary mental health care. Study participants also described that their usual 15- or 30-minute appointment times were not well suited to all patients seeking primary mental health care. More specifically, participants recognized that mental health specialists have more time and expertise to provide evidence-based therapy, such as cognitive behavioural counselling. The similarity of the findings from this study, with studies conducted in other parts of Canada, suggests that the issues described here permeate the Canadian primary care system. As we move to create primary care networks, we must consider increasing PCPs' mental health care competencies via pre-licensure education, while simultaneously attending to the PCPs' perceived time restrictions and need for consultation with mental health specialists.

REFERENCES

Anthony, J. S., Baik, S., Bowers, B. J., Tidjani, B., Jacobson, C. J., & Susman, J. (2010). Conditions that influence a primary care clinician's decision to refer patients for depression care. *Rehabilitation Nursing, 35*(3), 113–122.

Benzer, J. K., Beehler, S., Miller, C., Burgess, J. F., Sullivan, J. L., Mohr, D. C., … Cramer, I. E. (2012). Grounded theory of barriers and facilitators to mandated implementation of mental health care in the primary care setting. *Depression Research and Treatment, 2012*. doi:10.1155/2012/597157

Canadian Medical Association, College of Family Physicians of Canada, & Royal College (2013). *National physician survey*. Retrieved from http://nationalphysiciansurvey.ca/

Canadian Nurses Association. (2010). *Canadian nurse practitioner: Core competency framework*. Retrieved from https://www.cna-aiic.ca/~/media/cna/files/en/competency_framework_2010_e.pdf

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative research*. Thousand Oaks, CA: Sage Publications Ltd.

Clatney, L., Macdonald, H., & Shah, S. M. (2008). Mental health care in the primary care setting: Family physicians' perspectives. *Canadian Family Physician, 54*(6), 884–889. doi:54/6/884

Cochrane, J., Goering, P., Durbin, J., Butterill, D., Dumas, J., & Wasylenki, D. (2000). Tertiary mental health services: II. Subpopulations and best practices for service delivery. *Canadian Journal of Psychiatry, 45*(2), 185–190.

College of Family Physicians of Canada. (2015). *Requirements for residency eligibility*. Retrieved from http://www.cfpc.ca/Application_and_Requirements_for_Residency_Eligibility/

Craven, M., Cohen, M., Campbell, D., Williams, J., & Kates, N. (1997). Mental health practices of Ontario family physicians: A study using qualitative methodology. *The Canadian Journal of Psychiatry, 42*(9), 943–949. doi:10.1177/070674379704200905

Elsom, S., Happell, B., & Manias, E. (2005). Mental health nurse practitioner: Expanded or advanced? *International Journal of Mental Health Nursing, 14*(3), 181–186. doi:10.1111/j.1440-0979.2005.00379.x

Farrar, S., Kates, N., Crustolo, A. M., & Nikolaou, L. (2001). Integrated model for mental health care: Are health care providers satisfied with it? *Canadian Family Physician, 47*, 2483–2488.

Fickel, J. J., Parker, L. E., Yano, E. M., & Kirchner, J. E. (2007). Primary care—mental health collaboration: An example of assessing usual practice and potential barriers. *Journal of Interprofessional Care, 21*(2), 207–216. http://dx.doi.org.uml.idm.oclc.org/10.1080/13561820601132827

Fleury, M. J., Bamvita, J. M., Aube, D., & Tremblay, J. (2010). Clinical practice settings associated with GPs who take on patients with mental disorders. *Healthcare Policy, 5*(4), 90–104.

Fleury, M. J., Bamvita, J. M., Farand, L., & Tremblay, J. (2008). Variables associated with general practitioners taking on patients with common mental disorders. *Mental Health in Family Medicine, 5*(3), 149–160.

Fleury, M. J., Bamvita, J. M., & Tremblay, J. (2009). Variables associated with general practitioners taking on serious mental disorder patients. *BMC Family Practice*, *10,* 41-2296-10-41. doi:10.1186/1471-2296-10-41

Goisman, R. M., Warshaw, M. G., & Keller, M. B. (1999). Psychosocial treatment prescriptions for generalized anxiety disorder, panic disorder, and social phobia, 1991–1996. *American Journal of Psychiatry*, *156*(11), 1819–1821.

Gross, R., Olfson, M., Gameroff, M., Shea, S., Feder, A., Fuentes, M., … Weissman, M. M. (2002). Borderline personality disorder in primary care. *Archives of Internal Medicine, 162*(1), 53–60. doi:10.1001/archinte.162.1.53

Henke, R. M., Chou, A. F., Chanin, J. C., Zides, A. B., & Scholle, S. H. (2008). Physician attitude toward depression care interventions: Implications for implementation of quality improvement initiatives. *Implementation Science:* 3, 40-5908-3-40. doi:10.1186/1748-5908-3-40

Kates, N., Mazowita, G., Lemire, F., Jayabarathan, A., Bland, R., Selby, P.…Audet, D. (2011). The evolution of collaborative mental health care in Canada: A shared vision for the future. *Canadian Journal of Psychiatry, 56*(5), 1–10.

Kessler, D., Lloyd, K., Lewis, G., & Gray, D. P. (1999). Cross sectional study of symptom attribution and recognition of depression and anxiety in primary care. *BMJ (Clinical Research Ed.), 318* (7181), 436–439.

Kroenke, K., Spitzer, R., & Williams J. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, 606–613. doi:10.1046/j.1525-1497.2001.016009606.x

Leigh, H., Stewart, D., & Mallios, R. (2006). Mental health and psychiatry training in primary care residency programs: Part I. Who teaches, where, when and how satisfied? *General Hospital Psychiatry, 28*(3), 189–194. http://dx.doi.org.uml.idm.oclc.org/10.1016/j.genhosppsych.2005.10.003

Lesage, A. D., Goering, P., & Lin, E. (1997). Family physicians and the mental health system: Report from the mental health supplement to the Ontario health survey. *Canadian Family Physician, 43*, 251–256.

Lin, E., & Goering, P. N. (1999). *The utilization of physician services for mental health in Ontario*. Retrieved from http://www.ices.on.ca/~/media/Files/Atlases-Reports/1999/The-utilization-of-physician-services-for-mental-health/Full%20report.ashx

Lin, E. H., Katon, W. J., Simon, G. E., Von Korff, M., Bush, T. M., Rutter, C. M., … Walker, A. (1997). Achieving guidelines for the treatment of depression in primary care: Is physician education enough? *Medical Care*, *35*(8), 831–842.

Macfarlane, D. (2005). *Current state of collaborative mental health care*. Retrieved from http://www.cpa-apc.org/media.php?mid=204

Mitchell, P. B., Ball, J. R., Best, J. A., Gould, B. M., Malhi, G. S., Riley, G. J., & Wilson, I. G. (2006). The management of bipolar disorder in general practice. *Medical Journal of Australia, 184*(11), 566.

Rhodes, A., Bethell, J., & Schultz, S. (2006). Chapter 9: Primary mental health care. In *Primary health care in Ontario: A practice atlas* (142–160). Toronto, ON: Institute for Clinical Evaluative Sciences.

Rockman, P., Salach, L., Gotlib, D., Cord, M., & Turner, T. (2004). Shared mental health care: Model for supporting and mentoring family physicians. *Canadian Family Physician, 50*, 397–402.

Sherman, B. J., Gilliland, G., Speckman, J. L., & Freund, K. M. (2007). The effect of a primary care exercise intervention for rural women. *Preventive Medicine, 44*(3), 198–201. http://dx.doi.org.uml.idm.oclc.org/10.1016/j.ypmed.2006.10.009

Simon, G. E., & VonKorff, M. (1995). Recognition, management, and outcomes of depression in primary care. *Archives of Family Medicine, 4*(2), 99–105.

Simon, G. E., Katon, W., Rutter, C., VonKorff, M., Lin, E., Robinson, P., … Russo, J. (1998). Impact of improved depression treatment in primary care on daily functioning and disability. *Psychological Medicine*, *28*(03), 693–701.

Swenson, J. R., Aubry, T., Gillis, K., Macphee, C., Busing, N., Kates, N., … Runnels, V. (2009). Development and implementation of a collaborative mental health care program in a primary care setting: The Ottawa share program. *Canadian Journal of Community Mental Health, 27*(2), 75–91. doi:10.7870/cjcmh-2008-0019

Wang, J., Langille, D. B., & Patten, S. B. (2003). Mental health services received by depressed persons who visited general practitioners and family doctors. *Psychiatric Services*, *54*(6), 878–883. http://dx.doi.org.uml.idm.oclc.org/10.1176/appi.ps.54.6.878

Wasylenki, D., Goering, P., Cochrane, J., Durbin, J., Rogers, J., & Prendergast, P. (2000). Tertiary mental health services: I. key concepts. *The Canadian Journal of Psychiatry, 45*(2), 179–184.

Wener, P., & Woodgate, R. L. (2016). Collaborating in the context of co-location: A grounded theory. *BMC Family Practice.*

World Health Organization & World Organization of National Colleges. (2008). *Integrating mental health into primary care: A global perspective*. Retrieved from http://www.who.int/mental_health/resources/mentalhealth_PHC_2008.pdf

Wranik, D., Hanrahan, K., & Tarrant, F. (2012). Contractual arrangements and remuneration methods for interdisciplinary teams in primary care in public payer systems: A framework. Retrieved from http://primaryhealthcareteams.ca/wp-content/uploads/2016/07/Report-1-Inventory-of-PHC-Team-Compensation-Models-copy.pdf

Wranik, D., Korchagina, M., Edwards, J., Bower, I., Levy, A., & Katz, A. (2015). How best to pay interdisciplinary primary care teams? Funding and remuneration, a framework and typology. Retrieved from http://primaryhealthcarecareteams.ca/wpcontent/uploads/2013/10/PRPA-Final-Report.pdf