Integrated model for mental health care

Are health care providers satisfied with it?

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ABSTRACT

OBJECTIVE To determine whether health care providers are satisfied with an integrated program of mental health care.

DESIGN Surveys using a mailed questionnaire. Surveys were developed for each of the three disciplines; each survey had 30 questions.

SETTING Thirty-six primary care practices in Hamilton, Ont, participating in the Hamilton-Wentworth Health Service Organization's Mental Health Program.

PARTICIPANTS Family physicians, psychiatrists, and mental health counselors providing mental health care in primary care settings.

MAIN OUTCOME MEASURE Satisfaction as shown on 5-point Likert scales.

RESULTS High levels of satisfaction with the model were recorded. Family physicians increased their skills, felt more comfortable with handling mental health problems, and were satisfied with the benefit to their patients. Psychiatrists and counselors were gratified that they were accepted by other members of the primary care team. Areas for improvement included finding space in primary care settings and better scheduling to allow for optimal communication.

CONCLUSION Family physicians, counselors, and psychiatrists expressed great satisfaction with a shared mental health care program based in primary care.

RÉSUMÉ

OBJECTIF Déterminer la satisfaction des dispensateurs de soins de santé à l'égard d'un programme intégré de santé mentale.

CONCEPTION Des sondages au moyen d'un questionnaire envoyé par la poste. Les sondages ont été élaborés en fonction de chacune des trois disciplines et comptaient chacun 30 questions.

CONTEXTE Un groupe de 36 pratiques médicales de première ligne à Hamilton, en Ontario, participant au programme de la santé mentale de l'Hamilton-Wentworth Health Service Organization.

PARTICIPANTS Des médecins de famille, des psychiatres et des conseillers en santé mentale dispensant des soins de santé mentale dans le contexte des soins de première ligne.

PRINCIPALES MESURES DES RÉSULTATS La satisfaction mesurée à l'aide d'échelles Likert de 5 points.

RÉSULTATS On a relevé de forts degrés de satisfaction à l'endroit du modèle. Les médecins de famille ont perfectionné leurs compétences, se sentaient plus à l'aise de traiter des problèmes de santé mentale et étaient satisfaits des bienfaits apportés à leurs patients. Les psychiatres et les conseillers appréciaient avoir été acceptés par les autres membres de l'équipe de soins de première ligne. Les éléments à améliorer se situaient dans l'aménagement d'espace dans les milieux de soins de première ligne et l'établissement d'un horaire plus propice à une meilleure communication.

CONCLUSION Les médecins de famille, les conseillers et les psychiatres ont exprimé une grande satisfaction à l'égard d'un programme de soins partagés en santé mentale dispensé dans un contexte de première ligne.

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Integrated models of health care delivery rely on professionals from many disciplines, and implementing and sustaining new models requires the commitment of all participating providers. When evaluating new models for delivering health care services, provider satisfaction is often an important measure of feasibility. To date, while studies have discussed the advantages and disadvantages of models used in primary care, few have used provider satisfaction as a measure of success.

Provider satisfaction has been correlated with remuneration, physical arrangements, personal relationships, independence, professional achievements, and feedback.[1] In primary care, studies show family physicians' satisfaction is linked with greater openness toward patients, more attention to psychosocial aspects of care, and the accessibility of specialists.[2] Nurses' job satisfaction can lead to increased communication and less staff turnover.[3-5] Little information is available about the satisfaction of professionals in other disciplines working in primary care.

This paper discusses the satisfaction of family physicians, mental health counselors, and consulting psychiatrists with an integrated program of shared mental health care in primary care practices.

Shared mental health care

Among patients visiting family physicians, the prevalence of psychosocial problems is as high as 40%, and the prevalence of psychiatric disorders is as high as 25%.[6,7] Most of these patients receive treatment only from their family physicians. Results of an Ontario study showed that family physicians believed their role in delivering mental health services would improve if support were more accessible to them.[8] Bringing providers together in primary care settings is one way to assist family physicians in caring for their patients' mental health.[9]

Hamilton-Wentworth Mental Health Program

The Hamilton-Wentworth Health Service Organization (HSO) Mental Health Program is an example of a shared-care program that supports family physicians in providing mental health care. Goals of the program include increasing access to mental health care for primary care patients; improving patients' mental health outcomes; strengthening clinical and administrative links between primary care and mental health services; and increasing family physicians' skills, knowledge, and comfort in managing mental health problems.

Health service organizations are family practices comprising one to six physicians who are paid through capitation. While HSOs have existed for more than 30 years, little evidence suggests that physicians in HSOs have different practice patterns from physicians paid by the traditional fee-for-service method.[10,11] About half of all HSOs in Ontario are located in Hamilton; 40% of family physicians in Hamilton work in HSOs. The HSO Mental Health Program includes 87 family physicians in 36 practices serving a rostered population of more than 170 000 patients. More than 60% of these physicians have chosen to move into the types of groups suggested by Ontario's primary care reform program since this study was completed.

Each primary care practice has an on-site mental health counselor and a visiting psychiatrist. Counselors are registered nurses, psychologists, or people with university degrees in social work or diplomas in community work from recognized college programs. These people are recruited through a central administrative office that screens applicants and forwards resumes to physicians. Currently, there are 24 full-time-equivalent (FTE) counselor positions filled by 38 individuals. Available to practices from half a day to 5 days each week, counselors assess patients; provide individual, family, and marital therapy; facilitate treatment groups; and consult with and educate team members. On average, there is one counselor for every 7500 to 8000 patients.

Visiting psychiatrists are recruited through the mental health system in Hamilton and are paid by sessional fees. They consult with family physicians and counselors, do follow-up visits with patients, and conduct case reviews and educational sessions every 1 to 4 weeks. Two FTE psychiatrist positions are currently filled by 13 individuals. Counselors' and psychiatrists' time in practices is allotted based on practice size and need.

The central administrative office oversees and organizes schedules, evaluates work, develops educational and research projects for all providers, and is accountable for the program. This central team is made up of an 0.4 FTE director; one each FTE program coordinator, database manager, and research associate; and administrative staff. Evaluation includes collecting data on referral and discharge processes, characteristics of patients seen, patient outcomes, and patient and health care provider satisfaction. Funding for the program is provided through the Alternative Payments Branch of the Ontario Ministry of Health and Long Term Care.

Ms Farrar, Dr Kates, *and* **Ms Crustolo** *are on active staff, and* **Ms Nikolaou** *was on active staff when this article was written, at the Hamilton-Wentworth Health Service Organization's Mental Health Program in Ontario.*

METHODS

The survey was conducted by the central office as part of program evaluation. The sample included all family physicians, counselors, and visiting psychiatrists participating in the program between July and September 1997. Questions about provider satisfaction with various aspects of the program were developed and pilot-tested for face and content validity with 40 family physicians, 26 mental health counselors, and 11 psychiatrists in the program during 1996. Questions that were unclear were discarded. Surveys were developed for each discipline; each survey had 30 questions.

The questionnaire for family physicians addressed benefit to patients; disruption to office routines due to presence of team members; role of counselors and psychiatrists clinically and as educational resources; and effects of the team on physicians' understanding of community resources, counseling techniques, and diagnostic and treatment approaches. Mental health counselors and psychiatrists were asked about their satisfaction with acceptance in practices as team members, adjustment of practices to their role, work environments, involvement of other team members, cooperation from regional mental health services, their role as clinicians and educational resources in practices, and whether they would recommend this type of practice to a colleague.

In the absence of validated scales measuring providers' satisfaction with mental health care in primary care settings, criterion validity was not examined. Responders used a 5-point Likert scale: higher scores indicated greater satisfaction. A modified Dillman approach was used for survey collection[12]; there were three follow-up mailings and telephone solicitation to facilitate return of the surveys. Data were analyzed using SPSS, version 7.0.[13]

RESULTS

Response rate was 95% (74/78) for family physicians, 95% (36/38) for counselors, and 70% (9/13) for psychiatrists.

Results for family physicians demonstrated high levels of satisfaction with all areas. Overall, 100% of family physicians in the program were either satisfied or very satisfied with counselors, and 99% were satisfied or very satisfied with psychiatrists. Overall, 76% of psychiatrists and 91% of counselors were either satisfied or very satisfied with their roles in the program. Most (93%) psychiatrists and all counselors would recommend this type of practice to colleagues.

Findings were grouped into four key areas: adjustments made by practices to accommodate teams, services provided, communication, and supports for providers.

Adjustments made by practices to accommodate teams

Adjustments were needed to accommodate new professionals and new systems, and to encourage acceptance of the service. Overall, family physicians were very satisfied with the adjustments their offices made to accommodate counselors and psychiatrists and with how counselors' and psychiatrists' skills and attitudes matched the expectations of practices. While overall levels of satisfaction were high, satisfaction with work space received low ratings from counselors (3.9) and psychiatrists (4.2) (**Table 1**).

Table 1. Satisfaction of providers with adjustments to service delivery:
Scale 1—very dissatisfied to 5—very satisfied.

ISSUE	FAMILY PHYSICIANS	MENTAL HEALTH COUNSELORS	PSYCHIATRISTS
Counselors' understanding and respect for organization of practice	4.8	N/A	N/A
Overall fit* of counselor in practice	4.9	N/A	N/A
Psychiatrists' understanding and respect for organization of practice	4.6	N/A	N/A
Overall fit of psychiatrist in practice	4.7	N/A	N/A
Adjustments office had to make to accommodate the team	4.3	N/A	N/A
Acceptance as member of family practice team	N/A	4.5	4.3
Satisfaction with work space	N/A	3.9	4.2
Satisfaction with the way practice adjusted to your role	N/A	4.2	4.3

N/A—not applicable.
**Fit—skills and attitudes of consulting professional matching expectations of the practice.*

Services provided

Participating physicians were very satisfied with the overall performance of the mental health teams and the benefit to their patients. Psychiatrists and counselors were also satisfied with their role in primary care settings (**Table 2**).

Table 2. Satisfaction of providers with services provided: *Scale 1—very dissatisfied to 5—very satisfied.*

ISSUE	FAMILY PHYSICIANS	MENTAL HEALTH COUNSELORS	PSYCHIATRISTS
Clinical performance of counselor	4.9	N/A	N/A
Patient benefit from access to counselor	5.0	N/A	N/A
Clinical performance of psychiatrist	4.8	N/A	N/A
Amount of time available for each patient	N/A	4.3	N/A
Overall satisfaction with role in primary care	N/A	4.5	4 .1

N/A—not applicable.

Communication

Communication in primary care settings occurs through discussions, charting, and case reviews with all providers. Family physicians, counselors, and psychiatrists stated they were very satisfied with communication among team members. This indicates that providers were working together in a close and supportive manner (**Table 3**).

Table 3. Satisfaction of providers with communication in primary care: *Scale 1—very dissatisfied to 5—very satisfied.*

ISSUE	FAMILY PHYSICIANS	MENTAL HEALTH COUNSELORS	PSYCHIATRISTS
Counselor and psychiatrist keeping family physician informed about patients	4.7	N/A	N/A
Appropriate and legible charting	4.2	N/A	N/A
Accessibility of psychiatrist for telephone advice	4.5	N/A	N/A
Availability of family physician to discuss patients	N/A	4.2	N/A
Receiving patient updates from psychiatrists	N/A	4.1	N/A
Receiving patient updates from counselor	N/A	N/A	4.7

N/A—not applicable.

Support for providers

Family physicians, psychiatrists, and counselors working in primary care require support from each other and from the local mental health system when handling patients' problems. All providers expressed satisfaction with access to each other's expertise in mental health care. The area providing least satisfaction was "cooperation from mental health services in region" (**Table 4**).

Table 4. Satisfaction of providers with support received in primary care

ISSUE	FAMILY PHYSICIANS	MENTAL HEALTH COUNSELORS	PSYCHIATRISTS
Counselor's role as educational resource	4.2	N/A	N/A
Psychiatrist's role as educational resource	4.3	N/A	N/A
Counselor's role in increasing understanding of community resources	4.3	N/A	N/A
Psychiatrist's role in increasing understanding of treatment approaches	4.2	N/A	N/A
Amount of support or backup received from family physician	N/A	4.5	4.0
Amount of involvement of other team members	N/A	4.5	4.7
Cooperation from mental health services in region	N/A	3.6	4.1

N/A—not applicable.

Areas for improvement

The main source of counselors' dissatisfaction was the lack of good links with formal mental health systems, in which many of them had previously worked. Lack of private space to see patients was also a source of dissatisfaction for counselors (**Tables 1** and **4**).

In some HSOs, counselors' and psychiatrists' schedules made good communication difficult to achieve. Family physicians' time constraints occasionally limited communication. In some practices, psychiatrists and counselors indicated they would be interested in more contact with family physicians.

DISCUSSION

Studies have shown that two problems in relationships between psychiatrists and primary care physicians are lack of communication and lack of personal contact.[14] The more contact and communication there is between family physicians and mental health care providers the more continuity of care there is for patients, and this leads to better health outcomes.[15,16]

Collaborative models of mental health care delivery address these communication issues. Family physicians believe collaborative models decrease stigma

for patients and increase interaction between providers, which improves patient care.[9,17] Shared care also fosters better communication between secondary and primary care, and provides clinicians with more educational opportunities.[9,17] Psychiatrists agree with these advantages, but think that lack of secretarial support, increased travel time, and wasted time when patients miss appointments could be disadvantages to this approach.[18] Counselors see advantages in the variety of work, opportunities for early intervention and prevention, reduced stigma for patients, and better communication among professionals.[19] Disadvantages seen by counselors include heavy workload, professional isolation, inappropriate referrals from family physicians, and concern that their role was misunderstood by family physicians.[19]

In the Hamilton-Wentworth HSO Mental Health Program's approach, family physicians were very satisfied with the contact and communication among mental health team members, services provided, and supports. This was all achieved with minimal disruption to primary care offices. In this model, mental health care is provided in a similar manner to primary care. Patients are not "admitted" or "discharged," but move in and out of care based on their needs. Thus, continuity of care is enhanced for patients, and difficult issues can be monitored and discussed with colleagues over time. Psychiatrists are available to family physicians and counselors by telephone between visits, which enhances contact and communication. Referrals are facilitated because family physicians are familiar with the professionals to whom they are sending patients. Care is provided on-site so family physicians can participate during busy clinic days. Team members' working together on-site also increases opportunities for educating physicians in detecting and treating psychiatric and psychosocial illnesses and for exchanging information.

Data from this survey show that family physicians are satisfied with the changes their offices have had to make to incorporate a mental health component into their practices, with the care provided to their patients, and with their access to counselors and psychiatrists. Counselors and psychiatrists indicate they would recommend this type of practice to colleagues. The results of this study support the advantages indicated by professionals working in primary care. The disadvantages stated in the literature were not replicated in this study. Reasons for this could include design of the program, presence of a coordinating body, and attitudes of participating family physicians.

Editor's key points

- This program offers a new model for providing mental health care that integrates psychiatrists and counselors into 36 health service organizations (medical clinics with one to six family physicians remunerated by capitation).
- This study looks at how well satisfied the collaborating family physicians, psychiatrists, and counselors were with certain aspects of the program: integration of various professionals on the team, care provided by the various professionals, communication, and support team members provided to one another.
- The existence of a centralizing coordinating team; integration of family physicians at every step in planning, implementing, and establishing the program; and funds to compensate for costs incurred could explain the levels of satisfaction expressed by participants and the absence of negative effects reported earlier in other locations.

Points de repère du rédacteur

- Le programme de santé mentale de Hamilton-Wentworth est un nouveau modèle de dispensation de soins qui intègre des psychiatres et des conseillers en santé mentale dans 36 organisations de services de santé (cliniques médicales comptant de un à six médecins de famille rémunérés par capitation).
- Cette enquête montre que la satisfaction des médecins de famille, des psychiatres et des conseillers en santé mentale qui collaborent à ce programme est élevée en regard des aspects évalués (intégration des différe nts professionnels à l'équipe, satisfaction face aux soins prodiguées par les différentes professionnels, communications entre les professionnels, soutien entre les professionnels).
- L'existence d'une équipe de coordination centralisée, l'intégration des médecins de famille dans toutes les étapes de planification, d'implantation et d'évaluation du programme de même qu'un incitatif financier pour compenser les frais encourus pourraient expliquer le niveau de satisfaction élevé des participants et l'absence d'effets négatifs rapportés antérieurement dans d'autres milieux.

The central office coordinates the program and provides support to providers. A central coordinating team is rarely part of shared care models, and its presence might be one reason this model works. Involving physicians in all aspects of planning, implementing, and evaluating the program meant that participants were strongly invested in the program

and wanted to make it work in their practices. Participating practices are also given a small stipend to cover services used by team members.

Limitations and future directions

This research might be limited by the survey format, which could have affected results by limiting choices through use of a Likert scale and closed-ended questions. Future research in this area might be done by qualitative methods and could include investigation of the effect of increased provider satisfaction on patient outcomes and physicians' behaviour.

Conclusion

Providers play a key role in the success and acceptance of new health care delivery methods. Their satisfaction with new models can predict a models' acceptability. This type of information can also suggest changes needed to improve communication and cohesiveness among providers working in integrated models of health care delivery.

High satisfaction with the Hamilton-Wentworth HSO Mental Health Program demonstrates success in implementing clinical and operational components of the model. All providers believe this integrated approach to mental health care makes services more accessible and satisfying to patients, improves communication between specialties, and creates teams that deliver enhanced mental health care. To succeed, integrated models require a commitment to common goals, mutual respect and trust, flexibility, and regular communication from all providers.

Contributors

Ms Farrar, Dr Kates, Ms Crustolo, *and* **Ms Nikolaou** *were all involved in project design, development of measures, data analysis, and manuscript review.* **Ms Farrar** *and* **Dr Kates** *prepared the manuscript for publication.*

Competing interests

None declared

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