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Integrating Mental Health Services Within Primary Care Settings

The Hamilton Family Health Team

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Abstract: For 16 years, the Hamilton Family Health Team Mental Health Program has successfully integrated mental health counselors, addiction specialists, child mental health professionals, and psychiatrists into 81 offices of 150 family physicians in Hamilton, Ontario. Maximising the potential of a "shared care" model requires changes within the primary care setting, to support the addition of mental health and addiction professionals, active involvement of primary care staff in managing mental health problems of patients, and collaborative practice. This coordinated effort allow mental health treatment through onsite support from a mental health team and supplants the need to refer most patients to the mental health setting. This article reviews the evolution of the program and the changes made by practices with key lessons learnt. **Key words:** *collaborative mental health care*, *integration*, *primary mental health care*, *shared care*

Since 1994, the Hamilton Family Health Team (formerly HSO) Mental Health Program (HFHT-MHP) has successfully integrated mental health personnel, including psychiatric nurses, masters-level social workers, and psychiatrists into offices of family physicians in Hamilton, a community of 500 000 in Southern Ontario, Canada (Vingilis et al, 2007). In 2006, it added addiction specialists and child mental health professionals to supplement mental condition service delivery to family health teams (FHTs).

The program was originally established in recognition that primary care physicians played a central role in delivering mental health care in Hamilton, often with minimal support from external mental health services. Many individuals with mental health problems, often presenting with general medical symptoms or a concurrent medical condition, received no treatment, even though they frequently saw their family physician through the course of a year. To reach these individuals, a new model for delivering mental health care was considered necessary.

The shared care model, used by FHT-MHP practices, was also initiated to address problems identified in the relationship between local mental health practitioners and primary care services (Kates, 2008; World Health Organization and World Organization of Family Doctors, 2008). These included: (1) poor access for referrals from primary care to mental health services, in part, due to long wait times, (2) poor communication between mental health and primary care services, and (3) a perceived lack of understanding of and support for the role of the family physicians in delivering mental health care.

The core component of the FHT-MHP is the integration of mental health counselors

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and psychiatrists into the offices of local family physicians (Kates et al., 1997; Kates et al., 2001). By doing so, program developers anticipated that they would be able to:

1. Expand access to mental health and addiction care
2. Increase the mental health and addiction intervention skills and capabilities of primary care physicians
3. Smooth transitions between primary care practices, stand alone mental health services and community programs
4. Enhance the experience of patients seeking and receiving care
5. Augment clinical outcomes of family health teams providing mental health and addiction care
6. Use health resources more effectively and efficiently

Developers also wished to create a model that could be disseminated to other communities and practices in Ontario and to other jurisdictions in Canada and elsewhere.

THE SETTING

Funded by the Ontario Ministry of Health and Long Term Care, FHT-MHPs are now found in 81 locations throughout Hamilton, Ontario. They service the needs of patients treated by 150 family physicians who, between them, now provide care for almost 70% of the city's population. The majority are one or two physician practices although 4 of the practices have 5 to 7 family physicians.

Family health teams are Ontario's model of transformed primary care (Rosser et al., 2010). They involve groups of independent physicians working in interprofessional teams to deliver comprehensive services 24 hours a day, 7 days a week. The FHT model emphasizes chronic disease management, health promotion, disease prevention, and continuing quality improvement. Each FHT has a nurse and medical office assistant/receptionist. The physician, nurse, and administrative staff core team can be supplemented in most practices by a part-time dietician (half-day per physician per week) a visiting pharmacist, a health educator or an onsite counselor and psychiatrist.

Family physicians are funded on a capitation basis (a fixed amount per patient per month) with incentives for specific aspects of preventive care and chronic disease management. They are integrated within a common governance framework. For those involved in HFHT-MHP practices, the governance framework also includes a management team with responsibility for overseeing the mental health program.

MENTAL HEALTH AND ADDICTION OPERATIONS

The Hemilton Family Health Team–Mental Health Program increases access by assuring that specialists in mental health and addiction care are geographically and temporally available as well as by supporting primary care physicians as they enlarge their scope of practice to include evidence-based treatment of mental disorders (Craven & Bland, 2006). They use a "stepped" approach in a shared care model, whereby family physicians or nurses attempt to address mental health and addiction issues before involving part-time onsite counselors, addiction specialists, child mental health professionals, or psychiatrists. If necessary, for those with more severe illness, referrals may be made directly to secondary and tertiary services in Hamilton's mental health and addictions network.

The presence of psychiatrists, part-time counselors, addiction specialists and child mental health personnel in the primary care setting has increased referrals for general mental health assessments 11-fold. The increase has been maintained at this level for 15 years. Currently, the mental health team located in the FHT-MHP clinics receive more than 6000 referrals a year, almost 3 times as many as the total number directed to the city's 2 outpatient clinics in the mental health sector. It has also demonstrated significant improvements in symptoms and/or functioning for over 50% of people seen (Kates et al., 1999).

Mental health counselors

Each family physician, who has a patient panel of approximately 2200 patients, will

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have a part-time counselor working in their office (0.25 to 0.3 full time equivalents [FTE]). One full time counselor is considered sufficient to assist with 7000 patients. As a part of the FHT-MHP, there are 48 counselor FTEs working in the program. Seventy-four individuals fill these positions. Funding for the positions originated from and continues to be paid through the province's budget for primary care, as part of the allocation each FHT receives.

The counselors are predominantly registered nurses (RNs) and master level social workers (MSWs) with previous experience of working in mental health programs. They are accessible for any patient in the practice to which they are assigned. Initial triage redirects patients who may be more appropriately seen and assisted by a community agency, a specialist, or for whom self-management materials would be more suitable. After this triage process is complete, first contact with a counselor is made. Triage insures that counselors protect and use their time for individuals in greatest need of the type of services they provide.

Counseling is usually short-term using a "shared" model of care. Some individuals can be seen for more extended assistance, if required. Others may be seen intermittently on an "as needed" basis, often with months or even years between contacts. In essence, mental health counselors work in a similar manner to the primary care providers with whom they share clinical responsibilities.

Counselors also run groups and help to link individuals with community resources and local mental health programs. They are available to see emergencies as they arise. For individuals whose needs cannot be met in primary care, for example, those requiring more complex treatments, rehabilitation programs, or closer monitoring by a psychiatrist, they assist them to reach services located in the mental health sector.

Counselors typically see individuals with more severe problems, as well as those with significant situational stress or those who are in crisis. They are expected to be able to provide support for issues related to children and families, adults, and seniors, and for individuals with mental and addiction problems serious enough to require medication. Their roles are varied. With some individuals, they serve as care coordinators, facilitating plans initiated by another primary care staff member. For others, they serve as system navigators, psychotherapists, advocates, health educators, or assist with referrals to community agencies.

HFHT-MHP leadership has been defining and updating competencies of counselors assisting with primary mental health care, an emerging area of practice (Gagne et al., 2006). The skills of mental health clinicians working in more traditional mental health clinics need to be adapted to a collaborative approach in the primary care setting and to the comorbid patients that they see. These are reinforced by staff training and ongoing support from the program manager. Once these competencies have demonstrated that they bring increased value to patients, they will guide the criteria for recruitment, job expectations, and accountabilities, and will contribute to staff performance appraisals.

Psychiatrists

Psychiatrists visit each practice for approximately half-day per physician per month. They work predominately as consultants to the family physicians, the practice nurses and the mental health counselors. Approximately, 50% of psychiatrist referrals require a single visit. Others require a second or third appointment to complete an assessment, to answer complex diagnostic issues, and/or to stabilize symptoms with a new treatment. A few patients may be seen intermittently over a prolonged period. Psychiatrists may sometimes take responsibility for ongoing treatment of a patient but more often provide indirect care via case discussions and patient reviews. Regardless, they are available to assist other clinicians involved with patients between scheduled visits by phone or E-mail.

Psychiatrists are paid a flat rate for each half-day they work, whether this is spent assessing patients, discussing cases, or providing

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educational input to the team. This comes out of the Province's Primary Care budget. They receive supplementary income for time spent on the phone or to complete necessary paperwork in between visits.

Addictions and children's mental health specialists

In addition to psychiatrists and counselors, over the last 4 years the program has added 2 addiction specialists and 3 child and youth mental health professionals. Since these individuals support 150 family physicians, one of their primary roles is to increase the skills and capacity of counselors, family physicians, and practice nurses in managing child, youth, and addiction problems. They also provide some direct care, and lead case discussions and reviews, run groups, provide consultation to primary care staff members, and facilitate referrals to the child mental health and addiction systems. A child psychiatrist is available a half-day each week to consult by phone or in person with members of FHT-MHP team.

Coordination of the program

A small central management team composed of a manager, a medical director, and 3 support staff coordinates activities in the practices. Along with part-time leads for the child & youth, addictions, depression and peer support programs. They also provide ongoing support for psychiatrists, counselors, addiction specialists, and child mental health professionals and they assist with recruitment and evaluation of mental health personnel. It is their responsibility to set program standards, deploy resources, communicate with funding sources, and trouble shoot when problems arise and liaise with the Programs's funder, the Ontario Ministry of Health and Long Term Care. The management team's presence has played a key role in sustaining program success.

FAMILY AND MENTAL HEALTH TEAM COORDINATION

In HFHT-MHP practices, the goal is for all primary care and mental health team members to play a role in the provision of mental health care. Family physicians and nurses are the health professionals most likely to assist patients make lifestyle changes, such as reducing alcohol consumption, stopping smoking, managing stress, improving diet, or increasing physical activity levels. The goal, however, is for this to be a team effort. To promote team-based care, HFHT-MHPs attempt to maximize the roles of all team members. They come together periodically for clinical and administrative discussions, which generate opportunities to work collaboratively. For example, family physicians and practice nurses may work with the mental health team in performing telephonic monitoring and proactive follow-up of individuals with mental health problems. They may work together on supportive counseling by assuring appropriate use of stress management techniques and assisting patients with illness and family support.

The family physician

Family physicians, by the nature of primary care clinics, see all individuals with mental health problems though they may refer some for treatment by other professionals. The presence of the mental health team increases their confidence, skills, and comfort in assessing and also managing mental health problems. With ready support, they are more likely to seek information about mental health and addiction problems as potential contributors to total health outcomes (Farrar et al., 2001).

Mental health and addiction education for family physicians in HFHT-MHP clinics is primarily case-based and often informal. Each person seen by or discussed with a counselor or psychiatrist provides a learning opportunity that can be generalized to similar patients during future clinical encounters. Traditional 60-minute continuing education presentations on a topic, such as depression, are largely replaced by 30 2-minute patient-centered educational experiences that not only increase the family physician's knowledge base but can be applied directly to current and future patients.

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The practice nurse

Family health team practice nurses assist patients with acute and chronic medical diseases. In the course of their work, they also help individuals with mental health problems, including delivery of supportive counseling or linking patients to mental health resources and other community programs. Because they work with patients who have compromised health, they can assist with coexisting mental health problems or the social and emotional consequences of their illnesses. These roles are facilitated if they have received training in special techniques such as motivational interviewing. Access to and support from the mental health team also increases their willingness to perform these tasks.

Many practice nurses in FHT clinics have seen trained to complete the 18-month well-baby visit, a routine examination in primary care in Ontario (William, 2008). They will then monitor children prospectively and can refer an emerging child or family problem to the mental health team, if necessary. Children at risk or showing early signs of emotional, physical, or developmental problems thus can receive early intervention. Practice nurses and physicians use a child and youth mental health assessment questionnaire to identify problems in children and teens. They also employ the patient health questionnaire-9 (PHQ-9—a depression screener) and a 2-question alcohol screen in teens and adults.

Pharmacists

Pharmacists can assist with reconciling prescriptions taken by patients. This ensures that everybody involved in their care knows exactly what medications are being prescribed and taken, the side effects, and potential drug interactions. They especially target patients using multiple medications, which often include at least one psychotropic medication. Their role also includes providing patients with health "passports" that list all current medications. This document, carried by the patient, is helpful when patients see multiple clinic and hospital physicians.

Psychiatrists and family physicians confer with the pharmacists. This allows them to easily access up-to-date evidence-based literature about drugs and drug interactions. The program is also piloting a group for individuals with chronic pain and excessive opiate use, which is co-lead by a pharmacist and mental health counselor.

Dieticians

Dieticians screen individuals with diabetes for depression, using the PHQ-2, a "triage" subset of the PHQ-9. Many also identify mental health problems in obese children and adults. When appropriate, a referral to the counselor or back to their family physician is made. In addition, they are also involved in assisting patients with eating disorders in conjunction with mental health counselors.

Medical office assistants

Medical office assistants in HFHT-MHPs often have ongoing relationships with patients seen by clinicians in the practice. They interact with them in the waiting room and by telephone. Occasionally, their knowledge of a person's family or their community activities contributes to a better understanding of patient problems. It is these office professionals who may distribute and collect screening tools and satisfaction surveys. They also provide information about community resources under direction of clinical staff and give out educations materials.

IMPROVING ACCESS

Although locating psychiatrists, mental health counselors, addiction specialists, and child mental health professionals in family practice settings is one way to improve access, waiting lists can still develop. This can be avoided by using the HFHT-MHP team to "share" accountability for mental health outcomes. Referred patients are thus transferred back to their family physician after assessment or when the clinical condition suggests that they would be able to effectively treat the patient. The mental health team, now familiar with the patient, can be consulted again at any

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point during the same episode, or in between episodes for further advice.

Close proximity of mental health professionals also promotes informal discussions and case reviews of patients who may not need to be seen directly. Advice about management can be provided and a plan implemented. Psychiatrists, counselors, addiction specialists, and child mental health professional are available for follow-up if the initial plan is not successful. Finally, the mental health team can facilitate referral of patients with serious or persistent mental or addiction problems to stand alone mental health clinics for more intensive intervention when appropriate.

The leadership team for FHT-MHPs is exploring other ways to improve access for patients. For instance, a walk-in clinic is being piloted in one of the larger and busier practices for a half-day each week. They are also investigating ways to use clinician time more efficiently. The starting point for this is attempting to match supply with demand. On the demand side, the number of people likely to be referred for mental health assessment and treatment and the number of visits each referred patient requires is estimated. This must then be matched to the number of appointment slots for counselors, psychiatrists, and other mental health personnel available per month or year.

In addition to matching benchmarked need with mental health professional availability, the HFHT-MHP leadership team also looks for ways to reduce demand or to manage it differently. For instance, as with the introduction of addiction specialists and child mental health professionals, indirect assistance to family physicians and practice nurses through case reviews, the development of care plans, referral to community resources, or early referral to the mental health sector can influence the number of patients effectively treated when demand outstrips supply.

Reducing the frequency of visits or the length of appointments (both potentially freeing up appointment slots for other cases) can increase supply for selected cases without affecting outcomes. The use of E-mail and telephonic follow-up, rather than in office visits, for certain problems, however, is one way that time can potentially be saved. "Electronic" intervention is likely to grow because it efficiently uses the time of provider and patients. Such an approach allows patients to minimize travel and wait times, to avoid time away from work, and to decrease the need to hire a babysitter for what may be just a 10-minute appointment. Increased use of the telephone also enables programs to monitor the progress of patients during treatment and after an episode of care has been completed.

ENHANCING THE CONSUMER EXPERIENCE

From the outset, the program has focused on providing ready access to mental health care in a location that is comfortable and easy to reach for patients with a mental health problem. The program is now exploring ways to improve the experience of those seeking and receiving care.

One way of doing this is to draw upon the experience of the person using services, by understanding the individual's health journey. Thus, recent FHT-MHP enhancements have come through direct patient input from satisfaction questionnaires, focus groups, and "shadowing" exercises. This has enabled the HFHT-MHP development team to draw on experiences that consumers actually receive. Although questionnaires have consistently documented high levels of satisfaction in receiving mental health care in the family physician's office and the attendant lack of stigma associated with it, consumer input has led to expansion of the ways it supports self-management and the introduction of a peer support program for individuals with depression.

BENEFITS OF THE PROGRAM

Early qualitative assessment suggests that HFHT-MHPs improve:

- Access to mental health care, particularly for individuals who come from communities that may traditionally

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underutilize mental health services. This includes ethnocultural groups where family physicians or practice nurses may speak a person's language or understand their culture, something that may not happen in stand alone mental health clinics.

- Access to mental health and addictions care for children (14% of referrals) and seniors (8% of referrals [over 65]) who may otherwise experience lengthy waiting lists for services
- Reduced waiting times for an initial assessment
- Earlier detection and treatment of mental health and addiction problems
- Expanded capacity of primary care to deliver mental health and addictions care as an integral part of the local mental health network of service
- Patient comfort in seeking and receiving mental health and addictions care from a health location that is more convenient and has less attached stigma
- Communication and coordination of care among providers, creating a continuum of care from primary to secondary to tertiary services
- The integration of physical and emotional care
- Secondary and tertiary mental health service efficiency by triaging patients in primary care before referral
- Outcomes of individuals with mental health and addiction problems seen in primary care settings (Kates et al., 2008)

KEY ENABLERS OF SUCCESS

Key factors, which have contributed to the success of the HFHT-MHP clinics, are:

- Having a clear vision and direction for the program from the outset
- Seeing the HFHT-MHP as a partnership between mental health and primary care, with each contributing to the program design. This required 1 to 3 visits to each practice before starting each FHT-MHP clinic. It assured that needs were identified and that primary stakeholders were clear about the expectations and limitations of the model before it started.
- Customizing the HFHT-MHP model to each clinic's patient population, staff, and resources within the clear guidelines laid down by the program management team. Personnel in each practice contributed to the development of their own program.
- Psychiatrists, counselors, addiction specialists, and child mental health professionals who are well prepared through orientation and ongoing educational activities to work in primary care settings
- Care is shared by the mental health and primary providers, according to their respective skills, comfort, and availability
- Assistance from a management team in coordinating the practice activities and resolving problems
- Family physicians willing to participate in program activities, particularly in discussing cases with any of their mental health team colleagues.

SPREADING THE MODEL TO OTHER LOCATIONS

Family Health Team Mental Health Program clinics were fortunate to receive funding to test and develop new ways of linking mental health and primary care services. Through the years, the FHT-MHP has expanded and now shares its expertise and experiences with clinicians and service planners from other communities and jurisdictions. Over 100 visitors from every province in Canada and from 12 countries have reviewed practices of the HFHT-MHP approach to primary care-mental health integration. Family Health Team Mental Health Program staff have also consulted to fledgling programs in Canada and internationally. The model has become a prototype for other FHTs in Ontario.

Staff of the program were instrumental in developing a 1997 position paper on shared mental health care in Canada (Kates et al., 1997) that led to the establishment of a conjoint working group of the Canadian Psychiatric Association and College of Family Physicians of Canada, which continues to meet

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(Kates, 2002). The work of FHT-MHP clinics was acknowledged with a significant achievement award from the American Psychiatric Association in 1999 (Kates, 1999).

FHT-MHP LIMITATIONS

Despite the support the model has received in terms of funding by the Province's Primary Care budget and the contribution to patient and primary care physician satisfaction, as manifest by its expansion of services, some limitations remain. A single or part-time psychiatrist supported counselor is often not able to meet the range of needs of a practice. In addition, to maintain access, the emphasis is on short-term counselor interventions, thus some cases may not receive the more intensive treatment they require. Further, the large number of small practices in the program creates recruitment, training, and mental health professional distribution challenges; for instance, larger practices have greater ability to divide a counseling position between 2 individuals, broadening the skills available.

Another limitation is that FHT-MHPs have not been able to compare their clinical and fiscal outcomes with outcomes from FHT practices without MHPs in place. It thus remains to be proven to what extent the addition of counselors and psychiatrists in the format described is associated with value to (*Note:* The program has demonstrated significant improvement in outcomes but has no financial data [see page xxx]) Canada's health system in terms of total health cost reduction. A systematic review of controlled studies of counseling in the primary care setting suggest that patient satisfaction is improved and modest short-term reductions in psychological symptoms in a cost neutral environment may occur but that long-term improvement and cost lowering remains to be demonstrated (Bower & Rowland, 2006).

FUTURE DIRECTIONS

Future FHT-MHP plans include:

- Transition to a more "consumer-centered" model of care. This reflects FHT-MHP clinic's increasing emphasis on the quality of care delivered and using quality indicators as measures of the program's success.
- Improved patient safety, that is, making sure we do not do anything that is likely to cause harm to a person or delay the initiation of needed treatments. This includes: (1) the rapid transmission of clinical information among providers; (2) immediate discussion of patient care plans; (3) medication reconciliation at each visit; and (4) providing consumers with copies of relevant notes and letters written on their behalf and of their care plan.
- More efficient and effective use of team-based care and full participation of all primary care providers in delivering mental health and addictions care
- Use of information systems to enhance mental health care, including computerized screening tools and treatment algorithms
- Innovative ways to deliver care, such as through telephone visits, e-mail, web-based resources, peer support, and support for self-management
- Population-based care with prevention, health promotion, and proactive care activities. This would include panel management, telephone reminders about appointments, and a greater emphasis on early detection.

SUMMARY

For almost 17 years the Hamilton FHT-MHP has successfully integrated mental health counselors and psychiatrists in to the offices of what is now 150 family physicians. Over that time the program has recognized not only the many benefits of colocating services, and the key factors that make it work, but also the need to make other changes in the primary care practices to optimize the potential that collaboration offers. These have included ways to improve access to care, enhance the experience of those seeking care, and a move toward more proactive, population-focused care.

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The FHT-MHP is a model that not only supports primary care providers, but also it is also comfortable and nonstigmatizing for people using the service. When the economic value of the approach has been demonstrated, it will offer important lessons for other communities in Canada and internationally.

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