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A thesis submitted in partial fulfillment of the requirements for the degree in Master of Clinical Science

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PSYCHOTHERAPY IN FAMILY MEDICINE

(Thesis format: Integrated Article)

by

Saadia Hameed MBBS CFPC

Graduate Program in Family Medicine

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master in Clinical Science in Family Medicine MCISc (FM)

The School of Graduate and Postdoctoral Studies
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London, Ontario, Canada

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Abstract

Aim: To explore the perspectives and practice of psychotherapy of family physicians, and analyze Ontario's mental health policy documents within the context of psychotherapy.

Methods: In the first study descriptive qualitative methodology was used. Eighteen family physicians were interviewed and the results were presented thematically. In the second study, a policy analysis of Ontario's mental health policy documents was conducted. The qualitative policy analytic methodology of Peter et al. was used.

Findings: Psychotherapy is an effective treatment of mental illness and is practiced by family physicians. Lack of training and time are barriers, while patient needs and shared care are facilitators for their practice of psychotherapy. Access to insured psychotherapy in Ontario is poor. However, there is neither a discussion of psychotherapy in the mental health policy documents, nor a plan to improve it.

Conclusions: More collaborative mental health care, equitable access to psychotherapy and family physician training in psychotherapy are needed.

Keywords

Family Medicine, Psychotherapy, Counseling, Primary Care, Shared Primary Mental Health Care, Collaborative Mental Health Care.

Co-Authorship Statement

The research for this thesis was conceived, planned and conducted by the author.

The following contributions were made:

Drs. Evelyn Vingilis and Laura Lewis provided advice and guidance regarding the research protocol and ethics submission. Both the above and Dr. Stephen State also helped to develop the analyses of the qualitative data from the interviews and from the policy documents.

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Dedication

For

Ahmed Raza Jan

and

Hadi, Asmaa and Dawud

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Chapter 1

1 Synopsis of the Thesis

1.1 Introduction

In modern psychiatry, there are three approaches to treating mental illness: 1) psychotropic medications, 2) psychotherapy, and 3) psychosocial rehabilitation.(1)(2)(3)(4) The main focus of this thesis is on psychotherapy.

Psychotherapy has historically been seen as a “softer science”, and due to its highly contextual and specialized delivery, is challenging to research. Most of extant literature supports the effectiveness of psychotherapy for the treatment of mental illnesses; however, there are many variables that affect the outcomes of psychotherapy.(5)(6)(7)(8)(9) As health care systems become more fiscally aware, more research on the cost effectiveness of psychotherapy in the management and prevention of mental illness has been emerging with promising results.(10)(11)(12)

Psychotherapy can be provided to patients by many mental health professionals. For example, by non-medical professionals such as psychologists, social workers, counselors and religious healers or leaders and by medical professionals, such as physicians and psychiatrists. In a recent survey of family physicians, almost 70% of them responded that they provided psychotherapy to their patients.(13) However, according to the results of the Canadian Community Health Survey in 2012, one third of Canadians reported having unmet mental health needs. Counseling was the most common type of mental health care need cited by Canadians aged 15 and older, yet counseling was also the need that was least often reported as met.(14)

Insured services are those health care services that are funded by the public health system and in Ontario is called Ontario Health Insurance Plan (OHIP). Psychotherapy is an uninsured service in Ontario, unless provided through hospitals, special community programs, or Family Health Teams. Family Health Teams have trained professionals who provide therapy free of cost to patients.⁽¹⁵⁾¹ These services are not universally available to all Ontarians, creating an accessibility and equity challenge with respect to psychotherapeutic services in Ontario. Limited information is available about psychotherapy in primary health care with regard to the practice of psychotherapy, the factors affecting the practice of psychotherapy (both barriers and facilitators), and how psychotherapy is affected by health policy.

1.2 Objectives

This thesis aimed to explore psychotherapy in family medicine (or primary health care) by designing two complimentary studies using qualitative methods of inquiry.

The objective of the first study was to explore the perspectives and practice of psychotherapy of family physicians, from London and Southwestern Ontario.

Specifically, the study explored: 1) family physicians' definitions of psychotherapy; 2) participants' perceived scope of practice with respect to psychotherapy; 3) factors affecting the practice of psychotherapy in family medicine; and 4) the physician as a psychotherapist.

¹ Mental health services can also be available free of cost through different ministries in Ontario, such as the Ministries of Child and Youth Services or Education.

The objective of the second study was a policy document analysis through the examination of Ontario's mental health policy documents within the context of the provision of psychotherapy. The study was guided by the critical theory approach of Duncan and Reutter(16), and the qualitative policy analytic methodology of Peter et al.(17)(18)

1.3 Overview of the thesis

Chapter one is a synopsis of the thesis. Chapter two is a literature review examining the burden of mental illness and management. The lack of a common definition for psychotherapy and counseling is elaborated and for the purpose of simplicity, the term "psychotherapy" is used in the thesis to include both psychotherapy and counseling. The literature demonstrates that psychotherapy is effective(5)(6)(7)(8)(19) and despite methodological challenges, there has recently been an increase in well-developed research on psychotherapy. There are many variables that affect the outcomes of psychotherapy including therapeutic alliance, therapist training and expertise, patient factors and therapy techniques.(20)(21) The literature suggests that the outcomes of psychotherapy are better when the therapist is well-trained, the patient is well suited to therapy and the right therapeutic technique is applied.

Psychotherapy falls within the scope of practice for family physicians (and specialist physicians) who, by virtue of their medical training, are allowed to perform certain controlled acts specified by the College of Physicians and Surgeons of Ontario (CPSO).(22) Most family medicine training programs in Ontario provide very little training in psychotherapy compared, for example, to programs in psychology or social

work.(23)(24)(25) Despite this, 70% of family physicians in the National Physicians' Survey reported that they practice psychotherapy on a regular basis.(13)

Chapter three is a qualitative study with a sample of family physicians in Southwestern Ontario. This chapter provides the findings of face-to-face interviews with family physicians to explore the perspectives and practice of psychotherapy of family physicians. Specifically, the study explores: 1) family physicians' definitions of psychotherapy; 2) participants' perceived scope of practice with respect to psychotherapy; 3) factors affecting the practice of psychotherapy in family medicine and 4) the physician as a psychotherapist.

Chapter four is a policy document analysis through the qualitative examination of Ontario's mental health policy documents within the context of the provision of psychotherapy. The study is guided by the critical theory approach of Duncan and Reutter (16), and the qualitative policy analytic methodology of Peter et al. which includes three forms of analyses: descriptive, conceptual and normative.(17)(18) The aim is to understand the values and principles underpinning national and provincial mental health and addictions policies. Specifically, the study critically examines how these policies are affecting the access and practice of psychotherapy in Ontario.

Chapter five integrates the findings from both studies and discusses the common themes that emerged.

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Chapter 2

2 Psychotherapy in Family Medicine

2.1 Introduction

Mental illness is characterized by alterations in thinking, mood or behavior (or some combination thereof) and is associated with significant distress and impaired functioning potentially over an extended period of time. The symptoms of mental illness vary from mild to severe, depending on the type of mental illness, the individual, the family and the socio-economic environment.(1)(2) Mental health is as important as physical health to daily living. Mental health and physical health are fundamentally linked. People living with a serious mental illness are at higher risk of experiencing a wide range of chronic physical conditions. Conversely, people living with chronic physical health conditions experience depression and anxiety at twice the rate of the general population.(1) Americans with major mental illness die 20 to 25 years earlier than the general population.(3) It is common for people to have multiple concurrent mental illnesses, such as mood, anxiety, or substance use disorders. In one US study, 54% of those with a lifetime history of at least one mental illness also had at least one other mental illness or addiction to substances.(1) Some common mental illnesses include: mood and anxiety disorders, personality disorders, schizophrenia, eating disorders, addiction disorders, post-traumatic stress disorders, bipolar disorders and other mental illnesses associated with special populations for example immigrants, children, special needs individuals and seniors.

Mental illnesses are caused by a complex interplay of genetic, neurochemical, biological, personality and environmental factors(4), and can affect anyone regardless of occupation, education, income level, and culture. The distribution is not uniform; some mental illnesses are more prevalent in people with poor access to social determinants of health, for example, poverty, housing and employment.(2) However, no one is immune, and at some point in their lives, all Canadians are likely to be affected by a mental illness in themselves, a family member or friend or colleague.

In 2002, Statistics Canada conducted the 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS), Cycle 1.2), which provided for the first time, national and provincial level data on mental illness in Canada.(5) One in five participants (20.6%) in the 2002 Mental Health and Well-being Survey (CCHS 1.2) met the criteria for a mood or anxiety disorder or substance dependence at some point during their lifetime - 24.1% of women and 17.0% of men.(2) Strict Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV) definitions for generalized anxiety disorder and substance use disorders were not used.

Ten years later, the 2012 Canadian Community Health Survey (CCHS) results showed the prevalence of mental illness had risen to include one in three (33%) Canadians. However, the 2012 survey included substance use disorder and generalized anxiety disorder, making the results from the two not comparable. In the last 15 years depression and bipolar disorders rates have remained the same, while substance abuse disorders have increased. Generalized anxiety disorder (GAD) is half as prevalent as depression in Canadians and more common in women, but unlike depression, GAD is prevalent across

all age groups equally.(6) By these estimates, mental illness is very pervasive and a significant problem in our society.

Impact of mental illness:

In developed countries, mental illnesses account for four of the leading 10 causes of disability.(1) Mental illnesses have a significant impact on the family as families may have to make difficult decisions about treatment, hospitalization, housing and contact with the family member with mental illness. Individuals with mental illness and their families face the anxiety of an uncertain future and the stress of what can be a severe and limiting disability.(1) The heavy demands of care may lead to burnout. Families may feel guilty about being the cause of illness.(1) The cost of medication, time off work, and extra support can create a severe financial burden for families. Both the care requirements and the stigma attached to mental illness often lead to isolation of individuals and family members from the community and their social support network, which may even lead to suicide.(1)(2)(7) Mental illness has a major impact on youth, being ranked as the second highest hospital care expenditure in Canada, surpassed only by injuries. Suicide is among the leading causes of death in 12-24 year old Canadians, second only to accidents.(4) Four thousand people die prematurely each year by suicide.(4)

On a fiscal level, the economic burden of mental illness is enormous. Health Canada's 2002 report, Economic Burden of Illness in Canada, using 1998 data, identified \$4.7 billion in direct costs for mental disorders. This does not include workplace costs, third-party insurance costs or the cost of services by mental health professionals who are not covered by health insurance plans.(2) In another Canadian study based on Health Canada

data, the estimated annual economic impact of mental health problems in Canada is \$14.4 billion.⁽⁸⁾ Another study estimated the incremental economic burden of mental illness in Canada which incorporated the use of medical resources and productivity losses due to short term and long term disability as well as reductions in health-related quality of life (HRQOL), for the diagnosed and undiagnosed population with mental illness. This analysis was based on the population based Canadian Community Health Survey cycle 2.1(2003) and reported the economic burden at \$51 billion.⁽⁹⁾ These numbers provide an idea of the enormous impact of mental illness and the challenges in fully assessing the fiscal impact.

From a more positive perspective, most mental illnesses are treatable.⁽²⁾⁽⁴⁾⁽¹⁰⁾⁽¹¹⁾. Some are even preventable.⁽¹¹⁾ Most of the extant literature on treatment of mental illness calls for a balanced combination of three fundamental approaches: medication (or pharmacotherapy), psychotherapy and psychosocial rehabilitation.⁽²⁾⁽⁷⁾⁽¹¹⁾⁽¹²⁾ Yet only a small minority of the millions of people suffering from a mental or behavioral disorder worldwide receive treatment.⁽⁷⁾

2.1 Managing mental illness

Historically, patients with mental illness were treated in “lunatic asylums” and mental care institutions. Mental illness was assumed to be a faulty trait in a person, which had to be broken and mended. The treatment philosophy was to coerce and use forceful measures; the methods were irrational and meant to correct a person’s faulty reasoning. In the last 150 years many people in such asylums developed disabilities secondary to social isolation. Due to public and academic criticism of these barbaric practices the “de-institutionalization movement” began.⁽¹³⁾ This was a complex process proposing that,

like any other illness, management of mental illness needed to be conducted within the community. Primary care was seen as the place where this care would ideally be delivered. It was clearly stated in the World Health Organization (WHO) Alma-Ata Declaration in 1978 that primary care had the most fundamental role in the entire health system in any country. This basic level of care acts as a filter between the general population and specialized health care.(1) In the last half century or so, many countries, including Canada, have integrated mental health care within primary care in the community with varying success. In Ontario, the transition is still ongoing with hospital expenditure on mental illness gradually declining and community mental care expenditure mounting steadily higher.(14) However, as the numbers of psychiatry beds (which are tied to provincial funding) have been cut back, a reciprocal increase in funding for community mental health services has been lacking.(13)

In the 2001, a WHO World Health Report recognized the major impact of mental health on humankind. The report put forth 10 recommendations to de-stigmatize mental illness and develop a workable plan to provide people with mental illness, effective and lasting treatment. These recommendations include the following: a) provide treatment in primary care; b) make psychotropic drugs available; c) provide care in the community; d) educate the public; e) involve communities, families and consumers; f) establish national policies, programs and legislation; g) develop human resources; h) link with other sectors; i) monitor community mental health and j) support more research.(15)(16) Most countries and jurisdictions including Canada and Ontario put forward revised mental health strategies in the wake of the World Health Report recommendations which are discussed in more detail in Chapter 4.

2.2 Treatment approaches

The comprehensive and ongoing management of mental illness for an individual requires a combination of medicines, psychotherapy and psychosocial rehabilitation. However, the two main approaches used in family medicine or primary care to treat different mental illnesses are psychopharmacotherapy and psychotherapy.

2.2.1 Psychopharmacotherapy

Pharmacotherapy with the use of psychotropic medications has brought about a revolution in the treatment of mental disorders. They are classified as: 1) anti-depressants; 2) anti-psychotics; 3) anxiolytics; 4) mood stabilizers and 5) hypnotics.

Their mechanism of action is thought to be a reversal of biochemical pathways that lead to symptoms of certain diagnosis, although actual mechanisms are not known completely.⁽¹⁷⁾⁽¹⁸⁾ Most of these medications work effectively and if prescribed and monitored appropriately.^{(17) (19)(20)(21)(22)(23)(24)(25)} They are specially effective when they are combined with psychotherapy.⁽²⁵⁾ They have given clinicians the ability to speedily bring symptoms of most mental illness under control and stabilize patients.⁽²⁶⁾⁽¹⁹⁾⁽²⁰⁾⁽²¹⁾

Most family physician have the knowledge and experience to prescribe these medications except for some mood stabilizers and anti-psychotics which may be best prescribed by psychiatrists.⁽²⁷⁾ However, medications do not work for all mental illnesses and as such, have their limitations.⁽¹¹⁾

As with all medications, psychotropic medications have side effects that have to be balanced with their effectiveness. Psychotropic medications can be associated with partial

remissions, frequent relapses or recurrence, persistent residual symptoms, distress and side effects.(28) Factors that affect how medications work in people include: 1) type of mental disorder; 2) age, sex and body size; 3) physical illness; 4) habits like smoking and drinking; 5) liver and kidney function; 6) genetics; 7) other medications like herbal/vitamin supplement; 8) diet, and 9) whether medications are taken as prescribed.(26) Thus, medications are effective in symptom reduction, although they fall short of being miracle drugs. Ideally, they should be prescribed along with life coaching and psychotherapy, which is supported by the literature.

2.2.2 Psychotherapy/counseling

The purpose of psychotherapy is to improve an individual's sense of his or her own well being and for exploring thoughts, feelings and behaviors. It is also employed for problem solving or achieving higher levels of functioning. There are many techniques that can be employed by different practitioners with different qualifications. Mostly, therapy is done by verbal communication (which is the mode that is assumed in this thesis) between the practitioner and the individual. There are other forms of therapy for example dance therapy, music therapy, drama therapy, art therapy and hypnotherapy.

Psychotherapy and counseling are practiced by different disciplines and as such definitions of psychotherapy and counseling vary, depending on discipline or group. In an exhaustive literature search on issues relating to psychotherapy regulation, the Health Professions Regulatory Advisory Council (HPRAC) of Ontario compiled and presented a discussion guide in 2005 that provided a list of different definitions of psychotherapy and counseling from different jurisdictions in Canada and the world, including the United Kingdom, Australia, New Zealand and the United States. (29) (for the actual definitions

please see Appendix 1). Most definitions are process based and refer to the use of specific techniques in psychotherapy to bring about change in thinking of the patient and alleviation in symptoms. Some definitions, such as the ones used by the Canadian Psychiatric Association, United Kingdom Council for Psychotherapy and the Canadian Mental Health Association, also add the pre-requisite that psychotherapy be practiced by a “properly trained professional”. Their definition also recommends that duration of therapy sessions be an hour or a fraction of. Some definitions are classifications that delve into the different theories and techniques of psychotherapy, such as individual therapy, group therapy and psychoanalysis. However, these definitions do not mention the criteria for choosing patients for the application of these therapies. The definition from The United Kingdom Council for Psychotherapy also specified end points or goals for psychotherapy: “individual becomes more autonomous and self-determined”. Other definitions also include diagnosis of a mental illness as a requisite to practicing psychotherapy but the majority defines it as a “talking cure” to bring about “positive change”. The New Zealand Standard of classification of occupations defines psychotherapy as a job description. Similar variation was found for definitions of counseling which encompassed a plethora of different techniques and competencies to bring about change in the patient or client (see Appendix 2).

In family medicine, the guidelines on the practice of psychotherapy by physicians (who are non-psychiatrists), published in 2010 by the General Practice Psychotherapy Association (GPPA) Professional Development Committee Guidelines Task Force(30), provides three different definitions of psychotherapy: 1) physician psychotherapy, 2) medical psychotherapy and 3) general practitioner (GP) psychotherapy:

“Physician psychotherapy is the deliberate establishment by licensed physicians of a professional relationship with patient for the purpose of communication and collaboration to address potential or actual health impacting problems.”
(31)(p.12-13)

“GP psychotherapy is the use of communication skills and use of self (the capacity to be empathic, genuine and transparent) to foster a therapeutic alliance with a patient in order to facilitate change, to cure illness, to relieve pain and to comfort,”(31)(p.12-13)

“Medical psychotherapy always entails continuing medical diagnostic evaluation and responsibility and may be carried out in conjunction with drug and other physical treatments. Medical psychotherapy recognizes that the psychological and physical components of an illness are intertwined and that at any point in the disease process, psychological symptoms may give rise to substitute for, or run concurrently with physical symptoms and vice versa.”(31)(p.12-13)

2.3 Effectiveness of psychotherapy

According to the American Psychological Association (APA):

“the effects of psychotherapy are noted in the research as follows: The general or average effects of psychotherapy are widely accepted to be significant and large, (Chorpita et al., 2011; Smith, Glass, & Miller, 1980; Wampold, 2001). These large effects of psychotherapy are quite constant across most diagnostic conditions, with variations being more influenced by general severity than by particular diagnoses—That is, variations in outcome are more heavily influenced by patient characteristics e.g., chronicity, complexity, social support, and intensity—and by clinician and context factors than by particular diagnoses or specific treatment “brands” (Beutler, 2009; Beutler & Malik, 2002a, 2002b; Malik & Beutler, 2002; Wampold, 2001)”.(32)

The evidence from rigorous clinical research studies show, what experts in the field consider, large beneficial effects for psychotherapy in comparison to no treatment, confirming the efficacy of psychotherapy across diverse conditions and settings.(33)(34)(35)(36)(37) There is a growing body of evidence that psychotherapy is cost-effective, reduces disability, reduces morbidity and mortality, improves work functioning, decreases use of psychiatric hospitalization, and at times also leads to reduction in the unnecessary use of medical and surgical services, including for those with serious mental illness.(32) Successful models of the integration of psychotherapeutic services into primary care have demonstrated a 20% to 30% reduction in medical costs above the cost of care that included psychotherapy. In addition, psychological treatment of individuals with chronic disease in small group sessions resulted in medical care cost savings of \$10 for every \$1 spent.(32) Current literature has established the effectiveness of psychotherapy irrevocably.

Recent advances in neuroimaging are clarifying that learning and environmental experiences, such as psychotherapy, change brain circuits as do drugs.(38) Hence, psychotherapies are being conceptualized as epigenetic drugs, potentially leading to a paradigm shift in psychiatry in that various standardized, brief, goal directed psychotherapies are being integrated with drug treatment of psychiatric disorders by physicians who have traditionally relied on a drugs only approach.(38)(39)

However, not all psychotherapeutic techniques fall under the rubric of empirically supported treatments (ESTs). Early poorly conducted research found psychotherapy to be no better than placebo,(40) or showed no difference in efficacy based on type of therapy used.(41)(42) Current ESTs are based on highly structured, brief, manual driven

interventions, primarily cognitive behavior therapy (CBT), frequently offered in a group setting, for treatment of specific disorders.(43) Hence, these therapies have become the most practiced and evidence based psychotherapy techniques in clinical psychology.(43)(44) Additionally, various types of family therapy(45)(46)(47), play(48), parent child(49), and other therapies, such as problem solving therapy(50) have also demonstrated positive efficacy results.

Research is far more limited on psychotherapy efficacy or effectiveness provided by family physicians. Most research in primary care settings evaluated psychotherapy provided by trained psychotherapists and not family physicians. Of the studies that have included family physicians, findings have shown mixed results. Most often family physician care is used for the control condition. For example, Freidli et al.(51) examined the efficacy of and patient satisfaction with family practice-based psychotherapists compared to family physicians in providing treatment to people with emotional difficulties. Family physician care was as effective as brief psychotherapy for patients, although patients preferred brief psychotherapy from a counselor. Similarly, Ward et al. found in a clinical trial that therapy conducted by counselors or psychologists was a more effective treatment for depression than usual family physician care in the short term, but after one year there was no difference in outcome.(52) Shandley et al. compared patient outcomes of therapist assisted, internet based panic disorder treatment for either patients referred by and supported by specially trained family physicians or for self-referred patients supported by psychologists.(53) Significantly more patients dropped out of the physician supported treatment. Better outcome was found for quality of life and for high end-state functioning post-treatment for the psychologist supported treatment, but no

other between-group differences were found for outcomes.(53) Alternatively, Huibers et al. conducted a Randomized Controlled Trial (RCT) to evaluate the efficacy of CBT by family physicians using a treatment manual for unexplained fatigue by employees and found no significant difference on primary and secondary outcomes between the treatment and control groups. They concluded that family physicians would be unlikely to successfully conduct CBT in routine clinical practice since they were unable to deliver the therapy effectively during the study.(54) Other studies have examined family physician effectiveness in treating depression with poor results although these studies supported family physician use of pharmacotherapy and not psychotherapy, e.g., Rollman et al.(55) However, some studies have considered short therapies, such as Motivational Interviewing as more applicable to primary care and chronic disease management. Rubak et al.(56) report significant outcomes through Motivational Interviewing by family physicians in effecting body mass index changes, total cholesterol, systolic blood pressure and blood alcohol concentration. However, the effects for hemoglobin A1c (blood test for the estimate of diabetes control) and number of cigarettes smoked in a day was equivocal. Using Motivational Interviewing for 15 minutes showed an affect. Anstiss (2009) opines that, “Motivational Interviewing is a proven and practical front-line approach which can help deliver goals in chronic disease management, whilst also helping to deliver such policy objectives and intermediate outcomes as increased levels of patient centered care, participatory or shared decision making, evidence based health care and improved clinical patient relationships”.(57)(p.89)

To sum, current literature asserts that psychotherapy works, and has moved on to the debate of how and for whom it works.(58) However, there have been growing concerns

about the future of psychotherapeutic services; this is in the context of more accountability and cost containment in healthcare spending, and hence a desire to clarify the scientific basis of psychotherapy treatments.(59) Recent effectiveness studies have also examined patient factors such as patient characteristics, age, environment factors, treatment approach and therapist characteristics, to better understand how psychotherapy works.(60) Researchers like Wampold, have identified empirically supported therapeutic relationships (ESTR) as a parallel concept to empirically supported treatments (EST).(42)(36) Patients' characteristics are said to predict outcome, and that some of these characteristics can be used to define an optimal or particularly good fit between the patient and the interventions used.(61) Some of these predictors will be discussed in the next section.

2.4 Predictors of psychotherapy outcome

There are numerous predictors or variables that affect the outcome of psychotherapy. Patient factors have been found to account for between 30% to 87% of the variance in treatment outcomes, while therapeutic factors (therapist based and process based predictors) have been found to account for 12% to 30%, depending on the study.(36)(62)(63)

2.4.1 Patient-based factors of psychotherapy outcome

Patient factors include but are not limited to demographics (age, gender, and educational level), culture (religious beliefs and beliefs about mental illness), diagnoses (Axes I and II, symptoms severity), individual (presenting problem and personality characteristics), attachment styles and patient perception of illness. For example, greater self-perceived

pathology and symptomatology were associated with greater improvement with psychotherapy(64), while the presence of personality disorders, chronicity and high initial severity of symptoms were negative predictors in short term therapy but were not associated with less favorable outcomes in long-term psychotherapy i.e., 2.5 years.(65) Avoidant coping style in patients predicted more negative symptoms and more psychological discomfort.(63) Non-English language speaking patients predicted worse outcomes (this effect was mediated by an avoidant coping style).(63) Examination of therapy dropout rates in the community found that early dropout rates were associated with being younger and being female, and having less severe symptoms of depression.(66) Dropout rate was slightly higher among clients from minority racial or ethnic groups.(66)

2.4.2 Therapeutic factors of psychotherapy outcome

Therapeutic factors include therapist-based factors, such as personal beliefs and traits, clinical expertise and professional training and process factors, such as psychotherapy technique and therapeutic relationship/alliance.

Personal beliefs and traits

There is some literature on the personal traits of therapists affecting the outcomes of psychotherapy. Sandell et al. found that the therapists who valued kindness, warmth and compassion as a curative factor and neutrality as a therapeutic style and who regarded psychotherapy as a form of artistry showed particularly positive long-term outcomes of psychotherapy.(67) Other literature shows that therapists' interpersonal problems did not impact patients' outcome.(64)(68) Therapists' personal beliefs and traits affect outcomes

of psychotherapy. However, there is not enough research in this area to enable us to accurately understand how much and in what way.

Clinical expertise and professional training

Clinical expertise refers to competence attained by psychotherapists through education, training and experience that results in effective practice.(69) The individual therapist has substantial impact on outcomes, both in clinical trials and in practice settings.(70)(71)(72)(73) The fact that treatment outcomes are systematically related to the provider of treatment (above and beyond the type of treatment), provides strong evidence for the importance of understanding expertise in clinical practice as a way of enhancing patient outcomes. Clinical expertise encompasses a number of competencies that promote positive therapeutic outcomes. These include: 1) assessment, diagnosis, systemic case formulation and treatment planning; 2) clinical decision making and implementation, and monitoring of patient progress; 3) interpersonal expertise; 4) continual self-reflection and acquisition of skills; 5) appropriate evaluation and use of research evidence in both basic and applied psychological science; 6) understanding the influence of individual and cultural differences in treatment; 7) seeking available resources as needed; and 8) having a cogent rationale for clinical strategies.(69) Expertise develops from scientific training, theoretical understanding, experience, self-reflection, knowledge of research and continuing professional education and training.(69)

Yet, other studies have found that professional psychotherapists' and paraprofessional therapists' therapy outcomes showed equal efficacy and effectiveness.(74) Professionals were defined as those therapists with baccalaureate degrees and extensive training.(75)

Stein and Lambert showed that professionals performed better where technique oriented therapy was utilized whereas paraprofessionals did better when nonspecific counseling was used.(34) They also calculated effect of experience of therapist in years practiced and found no supporting outcome for therapist experience.(34) However, other research found that more experienced therapists did better with child and adolescent therapy and professionals demonstrated better outcomes with children with severe symptoms.(75) Stein and Lambert also found that more experienced therapists has greater client retention compared to less experienced therapists.(34) They also found a modest effect size favoring professionals when client satisfaction and outcome were assessed at the end of therapy, when pre and post measures were used. Therapists with specialty training in anxiety disorders completed treatment faster than therapists without this training and patients had significantly lower rates of relapse over the two year period following therapy.(76) In another study by Bright et al., paraprofessionals were found to be efficient in CBT, but the professional led groups of patients showed better outcomes.(77) However, both groups showed no difference in adherence measures.(77) Professional therapists did better in patients and children with severe symptoms, when specific therapeutic techniques needed to be used, had better client satisfaction and dropout rates.(77)

In an earlier study, Nietzel and Fisher identified the need to account for confounding factors, including different therapies, characteristics of therapists and the differences in length of treatment between groups in studies conducted on “professional therapists” and “paraprofessionals”. They questioned the definition of professionals and paraprofessionals and recommended changes be made to reflect true clinical expertise

commensurate of the therapists' training and experience.(78) The definition of paraprofessionals is problematic in that it lumps together all the therapists who do not have a professional degree but who may have a wealth of training and years in experience. "Paraprofessionals" are a very heterogeneous group of therapists and may have excellent skills, life experiences in their special area of expertise, so research without accounting for this confounding factor, could be misconstrued. None of the later studies commented on the actual training that these therapists have had. Some therapists had supervision which was not accounted for in the studies. The methodological design of studies has also been criticized that they are not designed to investigate effects of therapist training per se, but as a secondary hypothesis, and hence are not planned well.(75)

In summary, although some studies have found limited effect of training and experience on psychotherapy outcomes, reviews and meta-analyses of psychotherapy outcomes provide modest, correlational data suggesting that a relationship exists between therapist training and outcome.(79)

Psychotherapy technique

The "process" of psychotherapy refers to the techniques that are used in psychotherapy, for example, cognitive behavior therapy, interpersonal therapy, solution focused psychotherapy and dynamic therapy. In contrast to large differences in outcome between those treated with psychotherapy and those not treated, different forms of psychotherapy typically produce relatively similar outcomes. Comparisons of different forms of psychotherapy most often result in relatively no significant difference, and contextual and relationship factors often mediate or moderate outcomes. These findings suggest that

most valid and structured psychotherapies are roughly equivalent in effectiveness.(80)(81)(82)

Therapeutic relationship/alliance

The consensus definition of therapeutic alliance is that it is an emergent quality of partnership and mutual collaboration between therapist and patient. In the early stages of therapy, treatment is built principally on a positive emotional bond between therapist and patient, such as trust, respect, liking and their ability to agree on the goals of treatment, and their establishment of a mutual consensus on tasks such as homework, dialogue, free association, that form the substance of the specific therapy.(83)(84)(85)

There are differences in the strength of the alliance-outcome relation depending on who rates the alliance and the therapy outcome i.e. patient, therapist or observer. In general, patient judgment provides the best prediction.(89) The correlation between alliance and outcome increases as treatment progresses over time, but alliance assessment early in therapy (third to fifth session) provides reliable prognosis, not only for outcome, but also for dropouts.(86) In a comprehensive review of extant literature on therapeutic alliance by the US National Registry of Evidence-based Programs and Practices,(86) the following conclusions were drawn. The development of a good alliance is essential for the success of psychotherapy, regardless of the type of treatment. The ability of the therapist to bridge the patient's needs, expectations, and abilities into a therapeutic plan is important in building the alliance. Because the therapist and patient often judge the quality of the alliance differently, active monitoring of the alliance throughout therapy is necessary. Responding non-defensively to a patient's hostility or negativity is critical to

establishing and maintaining a strong alliance. Patients' evaluation of the quality of the alliance is the best predictor of outcome; however, the therapist's input has a strong influence on the patient and is therefore critical.(86) However, most of this research has been conducted in outpatient psychotherapy settings.

Family physicians already have a therapeutic relationship with patients by virtue of their lifelong association. Borin and Morris opine that family physicians are unique in their continuing affiliation with individuals and families over time, allowing them to observe the dynamic connection of patients' diseases in a holistic context of family, community and work.(87) The trust and confidence that goes with this ongoing relationship allows psychotherapeutic interventions to have more of an effect because they are in the context of the whole person.(87)

2.5 Professionals, psychotherapists and training

Mental health services are provided to the public by a wide range of qualified professionals, for example counselors, counseling therapists, therapists and psychotherapists. Regardless of what professional titles are used, these practitioners utilize a variety of methods and techniques, including psychotherapy, to resolve many different types of cognitive, emotional and behavioral issues faced by their patients. Mental health professionals, both regulated and unregulated, operate in a wide range of arenas including hospitals, clinics, community agencies, schools, prisons, and many institutional and community-based programs funded by the provincial government. It is in the public interest for Ontarians to have the choice of a wide range of mental health services to ensure that the pool of qualified mental health care providers is not diminished, mental health services are available in remote areas, services are available in

languages other than English and French, services are available that are culturally competent and accessible to diverse communities.(88)

Public protection is vitally necessary because people receiving mental health care are vulnerable at the time in their lives when they seek assistance or treatment. All mental health professionals, regardless of the titles they use, pose a risk of harm to the public due to the nature of their work. Mental health practitioners will continue to provide much-needed services, and thus a broad spectrum of professionals needs to be regulated.(88)

The nascent College of Registered Psychotherapists of Ontario (CRPO) is the governing body of a new health regulatory college. It came into effect on April 1, 2015 after the proclamation of the Psychotherapy Act, 2007. This College is an umbrella organization to ensure that Ontarians have access to good quality therapy by a wide range of therapists. The College will establish guidelines around who can use the label of psychotherapist in Ontario, based on credentialing and training criteria. It is assumed that if physicians are to practice psychotherapy, bill for it and call themselves “GP psychotherapists”, they would have to register with the CRPO and undergo similar training and credentialing as other professional psychotherapists. However, this is yet to be determined.

Different countries and jurisdictions in the world require substantive training in order to be able to conduct psychotherapy. Appendix 3 shows the table taken from the discussion guide prepared by the HPRAC to guide discourse around the regulation of psychotherapy as a discipline in Ontario.(89)

Most programs require a very broad based and comprehensive curriculum leading to a degree program and beyond, and hundreds of hours of supervised therapy training. The

hours of supervised training required for accreditation range anywhere from 120 hours for counselors to over 700 hours for psychologists.

Psychologists need a doctoral degree from program of study with content that is primarily psychological in nature, to complete a period of post-doctoral supervised practice, to pass the written and oral examinations, to complete all further professional training or experience, to attend the interview conducted by the Registration Committee and pass the examination on legislation and regulation requirements as required in the guidelines published by the College, before they can become a member of the College of Psychologists of Ontario (CPO) and practice psychotherapy.

Social workers: according to the Canadian Association for Social Work Education (CASWE), in order to become a Social Worker in Ontario one needs to have a graduate or Master's degree and at least 500 hours of field work to practice.

Counselors in Canada need to show evidence of graduate course work in Counseling Theory and supervised counseling practicum with least 120 hours of direct client contact.

By these standards, the credentialing requirements to become a professional psychotherapist are very robust and intensive.

2.6 Family physicians as psychotherapists: training and regulation

2.6.1 Regulation of physicians with respect to psychotherapy

College of Physicians and Surgeons of Ontario

Physicians are regulated in Ontario under the Regulated Health Professionals Act (RHPA) through the College of Physicians and Surgeons of Ontario (CPSO). This is a

form of self-governance since the College is run by a council made up of elected physicians and other members. The College is responsible for ensuring that the medical profession complies with the legislation and by-laws of the RHPA, the Health Professions Procedural code (HPPC) and the Medicine Act.(90).

Controlled Acts

Physicians can perform fourteen controlled acts as listed in the CPSO documents on controlled acts (see appendix 4). Of these 14 acts, the last act, number 14, is relevant to the practice of psychotherapy by family physicians.

“14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual’s serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual’s judgment, insight, behavior, communication or social functioning.” (91)(92)

All physicians are allowed by this act to provide psychotherapy with the caveat that it cannot be delegated. There are no training requisites mentioned and the assumption is that the Medical Doctor degree (MD) is sufficient training for the practice of psychotherapy.

The Ontario legislation, through the psychotherapy act 2007, defines the scope of practice of psychotherapy as:

“The scope of practice of psychotherapy is the assessment and treatment of cognitive emotional or behavioural disturbance by psychotherapeutic means, delivered through a therapeutic relationship based on verbal or nonverbal communication.”(93)

2.6.2 Family physicians’ training with respect to Psychotherapy

The literature suggests that family physicians in Canada are not adequately trained to diagnose and treat mental illness and that they are not well trained to provide

psychotherapy services.(12)(94)(95) According to the literature mental illness is poorly diagnosed in family medicine or primary care. However, there is evidence that it is still possible to treat major depression well in primary care when good patient education, streamlining practice management, follow-up of mentally ill patients and psychiatric support are present.(96) Kessler et al. report that one of the reasons of poor detection of mental illness is a “normalizing style in patients” who present with symptoms that may not appear as severe as they are in life, which lowers the detection of their mental illness.(97) Swanson reports that family physicians perceive that about 30% of their patients have mental health issues that require psychotherapy.(98) However, 42% of family physicians reported that their psychotherapy training had been inadequate for their current practice needs.(98) Thirty four percent of physicians who thought that their training has been inadequate had acquired more training in psychotherapy. This suggests that family physicians may not be adequately trained to offer professional psychotherapy.(47) Contrary to this, Brown and Weston in their study examining training in psychological interventions, found that the majority of family doctors graduating from The University of Western Ontario during a specified period, felt satisfied by their ability to deal with psychological problems in family medicine.(95) Yet half of the participants felt that patients with psychosocial needs put a greater strain on them than other patient groups.(95) The physicians in this study had received postgraduate training in family medicine but no formal training in psychotherapy. In another study, Wiebe and Greiver found that family doctors (who had completed CBT training 6 months prior to the study) felt that having good training in mental health and therapy added to physician confidence in dealing with psychosocial issues.(94) This suggests that there is variability in training,

practice, satisfaction and perceptions about their psychotherapy skills in family physicians. This may also be in part, due to the personality of the family physicians, as some of them could be more interested in the diagnosis and management of mental illness; this could affect their self-awareness with respect to psychotherapy.

A review of undergraduate medical education curricula in medical schools and post graduate residency training programs in family medicine in Ontario shows that there are robust objectives for behavioral science and mental health care skills acquisition in the curriculum outline, but no consistent and formal program for training in psychotherapy per se. The McMaster undergraduate medical program offers a seven seminar module in solution focused psychotherapy, plus an online psychotherapy training e-resource (PTeR) on psychotherapy that has an inconsistent practical component.(99)(100)

University of Toronto post graduate program offers a horizontal elective (residents choose to do or not) program in the second year of residency, where they have the option of honing their psychotherapeutic skills.(101) Western University has a behavioral science program consisting of Academic Half-Day sessions on Wednesday afternoons as well as three small group sessions per year for case discussion. Residents participate in the small group sessions during their Family Medicine block time and cover topics such as interviewing, communication and relationship building skills; counseling and psychotherapy skills; normal psychological development; the key determinants of health and how they affect the health of patients and populations; dealing with difficult patients; and questions and answers for common psychiatric presentations and diseases.(102) However, there is no formal psychotherapy teaching or observation. Other post graduate programs across the country may have sound and robust objectives in teaching mental

health care skills as per the Canadian Medical Education Directions for Specialists-Family Medicine (CANMED-FM) objectives of the College of Family Physicians of Canada (CFPC)(103), but formal psychotherapy training and supervised practicum are lacking. In summary, family physicians' training is generally inadequate and heterogeneous with respect to psychotherapeutic skills.

2.6.3 Patient Centered Clinical Method

Medical students and residents are taught to have a holistic approach to treating mind and body in almost all the medical schools and training programs in North America. The patient-centered clinical method (PCCM) is a well-known entity and has its birth place in London Ontario.(104) Stewart et al. provide a theoretical framework for patient centered practice (see Appendix 5), with four integrated components which include: 1) exploring the patient's health, disease and illness experience; 2) understanding the whole person in their proximal and distal contexts; 3) finding common ground to make informed and mutual decisions, and 4) enhancing the patient-clinician relationship.(105) The PCCM seeks an integrated understanding of the patient in the context of their internal and external environments.(105) The PCCM is the bedrock of all clinical methods and communication in medical education across the country and most of the world.

One of the major differences between family medicine and other medical disciplines is the ongoing nature of the patient-physician relationship. The relationship develops over a lifetime and this allows the physician to see the same patient with different problems in different settings over a number of years. Additionally, the relationship allows the family physician to see the patient through the eyes of other family members. The physician's commitment is to "hang in" with the patient to the end. Patients need to know that they

can count on their physicians to be there when they need them. This ongoing relationship colors everything that happens between them and also puts the family physician in the unique position to offer mental health care in general and psychotherapeutic treatments in particular.(106)

Statistics from the 2007 Canadian National Physicians' Survey(108) indicated that about 70% of family physicians in Canada reported offering psychotherapy/counseling as part of their practice. Although there is a paucity of research specifically on psychotherapy in family medicine, the findings above show a paradox in research and practice. Family physicians are not well trained to practice psychotherapy but still profess to practice it substantially. As this literature review has documented, the prevalence of mental illness is high among Canadians, empirically supported treatments conducted by trained psychotherapists show positive outcomes and trained psychotherapists are available. These issues then, beg two sets of questions: 1) what kind of psychotherapeutic services are family physicians in Canada offering their patients, and 2) what is the government doing to support the provision of psychotherapy to Canadians? That is, what are family physicians' perspectives and practice of psychotherapy and what are the national and provincial mental health and addictions policies on the practice of psychotherapy in primary care?

Specifically, the objective of the first study is to explore: 1) family physicians' definition of psychotherapy; 2) participants' perceived scope of practice with respect to psychotherapy; 3) factors affecting the practice of psychotherapy in family medicine, and, 4) the physician as a psychotherapist.

The objective of the second study is to examine Ontario's mental health policy documents within the context of provision of psychotherapy.

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Chapter 3

3 Family physicians' perspectives and experiences of psychotherapy: a qualitative study

3.1 Introduction

In 1964 Michael Balint in his book "The Doctor, His Patient and The Illness" stated that,

"It is generally agreed that at least one quarter to one third of the work of a general practitioner consists of psychotherapy pure and simple. Some investigators put the figure at one half or even more, but, whatever the figure might be, the fact remains that present medical training does not properly equip the practitioner for at least a quarter of the work he has to do." (1)(p.107)

This statement likely still holds true today as it did in the mid twentieth century. Collins et al. in their 2006 cross sectional survey of 163 family physicians in the south western Ontario region found that 40% of family physicians devoted a "moderate" portion of their time to mental health issues. Most of this time was spent with adults(2). Despite the fact that 32% of participants reported using CBT, most physicians (78%) had not received training in CBT and reported having little knowledge of CBT.(3) This raises the question: how are family physicians practicing psychotherapy? Psychological therapies may be effective (4)(5)(6)(7)(8), but they often require much training to deliver, and require many supervised treatment hours to master (6)(7)(9)(10), as elaborated in chapter 2. If family physicians are not adequately trained to provide psychotherapy then how are they practicing it?

3.1 Purpose of the study

The overall purpose of this study was to explore the perspectives and practice of psychotherapy of family physicians in Southwestern Ontario.

Specifically, the study's intent was to explore: 1) family physicians' definition of psychotherapy; 2) participants' perceived scope of practice with respect to psychotherapy; 3) factors affecting the practice of psychotherapy in family medicine, and 4) the physician as a psychotherapist.

3.2 Methods

This study employed the qualitative descriptive method to elicit family physician's practice and perceptions of psychotherapy. Qualitative descriptive studies are the least theoretical of the spectrum of qualitative approaches, in that researchers conducting such studies are the least encumbered by preexisting theoretical and philosophical commitments. Qualitative Description is especially amenable to obtaining straight and largely unadorned (i.e. minimally theorized or otherwise transformed or spun) answers to researchers' questions such as who, what, and where of phenomena. Qualitative description is the method of choice when straight descriptions of phenomena are desired and as such it fits the purpose of our study well.(11)

3.2.1 Sample

A purposeful sample of key informants was recruited for the study. The family physicians were identified by the researchers based on prior knowledge and by asking other physicians in the community to identify key informants. The participants were individuals who were articulate, good communicators, open and prepared to share their personal and professional feelings, attitudes and experiences concerning psychotherapy in family medicine. Letters of information (see Appendix 6) about the study were sent via email to inform and obtain consent from potential participants. Participation was confirmed by phone or e-mail. Twenty physicians were contacted over the duration of the

study and 18 consented to take part in it. One family physician did not reply and the other refused to be interviewed, as, in his opinion, he did not practice psychotherapy so would not be a good informant. The interviews continued until thematic saturation was reached. It took a total of 18 interviews to reach thematic saturation.

Maximum variation with respect to sex, years in practice, practice model and practice location (rural vs. urban) was considered when identifying potential participants.(11) Thematic saturation was determined through an iterative process by the three researchers after 18 key-informant interviews.

Demographic data: There were 12 female and six male participants in this study. The ages of the participants ranged from 27 to 57 years and the years in practice ranged from < 1 year to > 29 years. Eleven physicians worked in a Family Health Organization (FHO), one was a solo practitioner, two worked in a Community Health Centers (CHC), two worked in a Family Health Team (FHT), two worked in a Family Health Group (FHG) and five also worked as full time academics. Fourteen participants worked in urban centers, one worked in the inner city, two had rural practices and one worked both in rural and urban areas. FHO, FHT, and CHC refer to remuneration models of the Ministry of Health and Long Term Care (MOHLTC) for physicians where they are paid per capita for enrolling patients in their practices. FHG is a fee for service model. Physicians in rural areas may belong to one of the above models or may be solo practitioners. Solo practitioners are also remunerated on a fee for service basis.

3.2.2 Data collection

Interview data were collected between January 2010 and April 2011. The key informant interviews were conducted by one of the researchers (SH) at a comfortable and mutually agreed upon venue. The interviews were audio taped in their entirety using two digital recorders. Field notes were also taken by the interviewer, during and after the interviews. The duration of the interviews was from 20 – 30 minutes. The interview format was semi-structured (See Appendix 7) with strategic probing questions (also in appendix), thus allowing for exploration of participants' perspectives and experiences concerning the practice of psychotherapy in Family Medicine. The goal was to get a good breadth of knowledge through the structured format and use the probing questions to gain in-depth information about participants' practices. The study proposal was reviewed by The University of Western Ontario Research Ethics Board for Health Sciences (HSREB) and approved on November 17th 2009; review # 16574E. (See Appendix 8)

3.2.3 Data Analysis

After each interview, the digital recordings were transcribed verbatim. The confidentiality of participants was assured by having the transcriptionist sign a letter of confidentiality. The transcription and notes taken were independently reviewed in detail by the three researchers to identify themes. Qualitative content analysis was the strategy used for this qualitative descriptive study.(11) It is a dynamic form of analysis of data that is oriented towards summarizing the informational content of the data. Once the researchers had reviewed the transcripts and emerging themes and sub-themes, they then met to compare and corroborate the findings. Multiple meetings were needed to review the individual interviews until thematic saturation of the data was reached. The

researchers communicated frequently in order to organize and re-organize the emerging themes. The interviews were conducted iteratively until all probable themes were uncovered. For this study, 18 interviews were required to reach saturation. Subsequent meetings between the researchers allowed further clarification of the over-arching themes related to the practice of psychotherapy in family medicine. NVivo 8.0 software was used to manage and classify the data into different nodes. This software allowed the researchers to code the data and organize it under different themes. The software program facilitated data management for this study.

3.2.4 Trustworthiness and Credibility

There are many aspects of trustworthiness and credibility in qualitative studies. These include reflexivity (a technique whereby the investigators turn the focus back on themselves in order to appraise their influence on the findings and analysis), depth of description, accuracy and rigor, intellectual honesty and a willingness to explore alternate explanations and interpretations.(12) These requirements were ensured by transcribing the interviews verbatim, taking field notes and member checking during the interviews and having all three researchers conduct the analysis. Member checking is a process where the researcher will restate or summarize information during an interview and then question the participant to determine accuracy of the information.(13) However, member checking was not performed after the data had been analyzed due the constraints of participants' workload and time.

3.3 Findings

Analysis of the data yielded three overarching themes: 1) definition of psychotherapy; 2) scope of practice of family physicians, and 3) factors affecting the practice of psychotherapy.

3.3.1 Definition of Psychotherapy

Surprisingly, all 18 family physicians that participated in our study were unable to define psychotherapy in a formal sense. There was much variability in their responses, and some participants had a general idea of the overarching concepts of psychotherapy. Some participants tried to list all the characteristics that they thought psychotherapy should have but other definitions were very simplistic. Overall, with most answers the researchers observed that family physicians had difficulty defining psychotherapy and differentiating between counseling and psychotherapy: *“I used to have the trouble of trying to figure out what is counseling and what is psychotherapy.”* Many participants viewed psychotherapy as a means of problem solving with their patients as one participant explained:

“When I think of psychotherapy I think of some sort of discussion between my patient and myself in regards to a certain medical issue that has a psychological component to it and hopefully together we are able to come up with some sort of solution to the issues that are raised.”

Some physicians defined psychotherapy as a method for changing behaviors in their patients, while others said that psychotherapy was any encounter with patients in the realm of mental illness: *“In general practice I would say it’s dealing with assessing, diagnosing, managing and developing treatment plans in the realm of mental health issues is how I would define the term...psychotherapy in family practice.”*

Most physicians defined psychotherapy as being structured and in which the therapist has been trained in a specific paradigm of psychotherapy.

“I find it’s pretty much structured. There is definitely a level of expertise that needs to be had to provide psychotherapy. Counseling, not to be flip about it, but anyone can be a counselor. We all do it. We all counsel friends and support people but I think that’s where the difference lies, when you enter a psychotherapy relationship you state that you can offer psychotherapy, there is a level of expertise and training that needs to be had.”

While some participants thought that psychotherapy was mere support and ventilation.

“Psychotherapy in my mind is very similar or synonymous with counseling and I think it is involving the patient in its communicative manner to explore their illness with a mental health problem.”

A couple of participants gave definitions that looked at psychotherapy as the healing emotion in a patient’s illness, for example: *“If the patient cries, then it’s psychotherapy.”*

Some physicians attempted to come up with what they felt would be a good definition of psychotherapy: *“I guess psychotherapy would be talk therapy and listening therapy and there are subdivisions of that with a purpose or a focus.”*

The information provided by participants suggests that they define psychotherapy as a combination of counseling, guidance, advice and education.

3.3.2 Scope of practice

Types of mental health issues seen in family practice

It was evident from the interviews that family physicians in the Southwestern Ontario region see a wide breadth of mental illness, from florid psychosis, schizophrenia, bipolar disorders to disorders such as mood and anxiety. They reported seeing patients with post-traumatic stress disorder (PTSD), personality disorders and substance abuse. Mental health presentations to the office also included childhood mental health issues such as

attention deficit and hyperactivity disorder (ADHD), learning disabilities and obsessive compulsive disorders (OCD). *“For children, primarily ADHD and behavioral issues and not all behavioral issues are psychiatric in terms of pathology, but ADHD by far is probably the most common complaint or the disorder that we look into or deal with.”*

By far, physicians reported seeing patients with mood and anxiety disorders the most: *“I think after 25 years we’ve seen most mental health issues and predominately depression and anxiety disorder.”* Family physicians also saw life stressors on a regular basis, for example, work place problems, parenting challenges, bereavement, crises of living like poverty and immigration adjustment issues, relationship crises and disability: *“Because I work in the inter-city population, there is a lot of addiction, a lot of anxiety secondary to poverty and other chronic illnesses like chronic pain.”* Also very commonly reported was mental illness associated with chronic illnesses like diabetes mellitus, fibromyalgia and chronic obstructive pulmonary disease (COPD): *“Majority of them are either patients that have major depressive disorder or fibromyalgia.”*

Types of psychotherapy practiced

Participants described numerous types of psychotherapy practiced by family physicians.

Ventilation and support: this was the most common form of psychotherapy participants said they provided their patients: *“For the most part I would say that what I do is ventilative and supportive work.”*

Cognitive behavior therapy (CBT): Many participants said that they used CBT or a modified brief version of CBT in their daily practice; however, many admitted to not having much training in this therapeutic modality.

“Sometimes I do use CBT cognitive behavioral mode. I haven’t developed sort of a really formal approach to that. I mean I have had a bit of training on it, and so sometimes I will have them fill out like a thought record.”

Insight oriented psychotherapy: A few participants reported using insight oriented psychotherapy as one participant stated: *“Insight oriented therapy, you know I use that term loosely.”* When asked to explain what that meant for him/her, the participant provided a definition for what he/she understood as insight-oriented psychotherapy: *“Insight oriented psychotherapy for me entails looking at the patient’s life and finding out who is this person, who is their contacts, who is their supports and how have they become perhaps depressed or anxious.”*

Psychoeducation: Most physicians reported using psychoeducation on a regular basis when seeing patients with mental health issues. One participant commented: *“some psycho education for all the disorders I think that that is an important component of people mastering their illness.”*

Solution-focused psychotherapy: Some participants reported using solution focused psychotherapy in their practice: *“And then there’s solution focus therapy, I use that quite often.”*

Motivational talk: Many participants mentioned using motivational talk for their patients in the context of chronic disease management.

“Well the fibromyalgia patients... giving them permission to talk about their illness and quite often a lot of them run into relationship difficulties because of their inability to, carry on with life and that sort of thing. I mean a lot of it too, is trying motivational psychotherapy, like trying to get people to get going.”

However, this participant did not use any of the formal motivational interviewing skills during their encounters with patients. The participants’ reported practice of

psychotherapy suggests that they may be actually practicing a combination of counseling, guidance, advice and education.

Role of medication in mental health care

Participants were asked how prescription medication was incorporated into their practice of psychotherapy. Most physicians described using psychotropic medications on a regular basis. As one participant explained:

“I would say that I prescribe medications more frequently than I would do CBT or counseling as a first line management for depression and anxiety primarily. I would say that only maybe ten percent of the people I have seen for mental health issues have been receiving counseling only without medication.”

However, participants had different reasons for using psychotropic medications. Most explained how medications were useful for symptom reduction.

“I don’t like the use of prescription medications. I’ll use prescription medications in the early stages of developing a therapeutic relationship with my patients who may have had a long history of mental health that has gone unchecked or unsupported, and so I usually describe it to my patients as I use medicines like I would use crutches if someone were to break a leg. This isn’t meant for a lifelong adjustment. This is more just to bring a quick solution or quick results as we deal with the therapeutic relationship and then again to take the medication away after a 12 to 16 week as they hit therapy and hopefully by that 4-month mark we’ve established a relationship where they feel safe and comfortable and we can start delving into certain elements and start building appropriate coping strategies and we can then titrate off the medicines. The caveat being that as everyone knows there is always a sub set of population that might need lifelong and they know that and I think that they appreciate that approach.”

Participants also articulated how their decision to prescribe medications was dependent on the diagnosis of a particular patient.

“It (prescription medication) fits hand and glove (with psychotherapy), I think, depending on the conditions so I have assessed and offer to the patient if they’ve had significant problems with anxiety, mood or sleep, Those would be the 3 things that I’d consider as a place for medication to help whatever the other problem is.”

For others, patients’ affordability of these medications was a factor in their prescription

Habits: *“It is very individual so it depends on the diagnosis, the patient, coverage Issues.”* Overall most physicians felt that both psychotherapy and psychotropic medications went hand in hand and were an adjunct for each other: *“I think that they go hand in hand.”*

“I’m a believer that they, that quite often patients require both, ... I mean I know that there are some psychiatrists that we utilize that aren’t big fans of psychoactive drugs but I think there are some people that truly benefit from it, so I feel pretty comfortable prescribing a wide variety of psychoactive medications.”

Similar to the last participant, most physicians felt comfortable with prescribing psychoactive medication. However, some comments alluded to a “prescription culture” prevalent in society in that there is an expectation to provide medication since they are so readily available, whereas, psychotherapeutic resources are limited and expensive.

“I think also it is patient preference, in a lot of cases people kind of expect now to get a medication to treat depression and anxiety and the other mental health diagnoses that we talked about as opposed to counseling only. I think to a certain extent there have been the patient expectations affecting that as well.”

Overall, most physicians were using both psychotherapeutic drugs and some form of talk therapy in the management of their mentally ill patients.

Practice descriptions

The researchers also wanted to understand how family physicians incorporated psychotherapy into their day-to-day practice.

Frequency of visits: Most participants explained that if a patient were in acute crisis, then they would see them on a weekly basis for supportive therapy but less frequently if they were stable. Some factors influencing the frequency of visits were cited as the diagnosis, patient stability, circumstances and patient supports and whether the physician had access

to shared mental care resources, for example a social worker, psychologist or liaison psychiatrist.

“I might see them once or even twice a week if they are going through a crisis or if I’m concerned that they have suicidal passive ideation and I might see them very frequently if they are in a crisis. Once they are controlled on medication then it is more support and psycho education, I might see them once a month. And then people who are on long-term antidepressants, may be twice a year even.”

Another reason for regular follow up was to see the effects of psychotropic medication, as one physician elaborated: *“So if it’s a condition where we have added some medication for depression or anxiety, we’d usually be following the person up within 2 weeks.”*

Appointment times: Most physicians admitted to usually spending half an hour for their psychotherapy sessions. One participant said,

“I book 30 minutes, and if we run over so be it we run over, and if we don’t use all of the 30 minutes then more often or not it is at least 20 minutes but usually closer to 30 by the time we wrap things up.”

And even if patients were scheduled every fifteen minutes, most physicians said that patient need would dictate the time spent with them,

“My average appointment time in my practice right now is 15 minutes, but that is the length of the booked appointment, although I would say that when patients come in who require counseling, it’s usually more like 30-45 minutes.”

Some participants booked therapy patients for an hour by virtue of being in a Comprehensive Care Model (CCM), where the compensation is not based on number of patients seen. However, the majority of the physicians in the province do not practice under this model: *“I’m very lucky in my model that I’m able to provide hour long appointments for my patients.”*

3.3.3 Factors affecting the practice of psychotherapy

The participants articulated how the practice of psychotherapy in family medicine was affected by many factors. When these factors were analyzed they fell under four overarching categories: 1) Physician Training Factors, which include adequacy of training, types of training received, informal training and need for training; 2) Logistical Factors, which include time, environment, administrative issues, compensation and shared care/resources; 3) Patient Factors; and 4) Physician Factors, which include pros and cons of practicing psychotherapy, concern with practice of psychotherapy, gender issues and motivation to provide psychotherapy. Some of these factors were reported to be facilitators to the practice of psychotherapy by family physicians, while other were seen as barriers. The following sections explore these factors in detail.

3.3.3.1 Physician Training Factors

Participants elaborated the types of training they had received for psychotherapy, both formal and informal. They also provided their opinions on whether the training they received was adequate for their practice of psychotherapy, and their needs around psychotherapy training.

Adequacy of training:

A major barrier to the practice of psychotherapy in family medicine emerging from the study was inadequacy of physician training. Many participants felt that the reason for them not providing psychotherapeutic services was feeling inadequately equipped to practice it.

“Level of comfort as well. I am not trained in sort of any psychotherapy in the sense of you know the CBTs or the DBTs so I am not sure if I would be able to provide the benefit expected from these types of things.”

“Well training would definitely be one of them (barriers), not feeling comfortable and part of that is because I haven’t spent the time to just...learn...for example CBT techniques in more detail. Anything probably other than CBT I would want more formal training and obviously there is formal training for CBT but I think you can kind of try and practice the basic concept of it.”

Inadequate training resulted in some participants feeling: *“ out of my element in many situations.”*

“I get the sense that it is a lot more formal than it is sort of perceived to be, so I wouldn’t say that I am an expert or that I am formally providing any form of psychotherapy per se.”

While others questioned if they actually did psychotherapy: *“If you look at the strict definition of psychotherapy, I am not sure if what I do is psychotherapy.”*

Some participants felt that their training had been adequate.

“I think relatively well. Again...it wouldn’t have prepared me well to be a cognitive therapist or behavioral therapist or an insight oriented psychotherapist. It prepared me to know the differences of the different type of psychotherapy and what pieces of those different sub areas I could use strategically and it helped me identify what’s the difference between doing counseling and not do psychotherapy as opposed to supportive psychotherapy. That is kind of a long answer. I guess the short answer is yes.”

A concern that quite a few participants expressed was that lack of training could lead to the possibility of patient harm in the practice of psychotherapy.

“I have concerns that we’re actually hurting people because as a whole I know I don’t have the skills I need to change people and I think to get those skills, they’re not easily acquirable in the amount of time I have during residency.”

While others reported that they had no concerns about the practice of psychotherapy in their discipline: *“I don’t think so. I don’t think I have any concerns. It depends because I feel family medicine psychotherapy is mostly supportive, not beyond that.”*

Note: the investigators noted a gender difference in the answers of this question and that theme will be elaborated on in the section on gender influences on the practice of psychotherapy.

Types of training received

The participants were also queried on the psychotherapy training they had received, and if they felt that it had prepared them for the practice of psychotherapy and what would their wish list be for training in psychotherapy at this stage in their careers.

Undergraduate medical education training: A minority of participants reported some teaching in the undergraduate medical education curriculum related to psychotherapy:

“So in medical school during my psychiatric rotation, we had some lectures about CBT and supportive counseling.”

Some participants went further and arranged elective time to hone their skills in psychotherapy; however, this was a self-directed endeavor. *“During my 4th year I did an elective, being able to follow three psychotherapists at that time. So that was more observational than skills acquisitions.”*

Residency training and electives: For many participants, the only formal training they received to practice psychotherapy was during their residency. Following are some quotes from participants which reflect the variability of their exposure to psychotherapy training during residency. *“I’d say the only training I’ve had is the bit of training that we had in residency so I don’t know if you could actually call that a formal training in psychotherapy or not.”*

“During residency we had specific half days in psychiatry and as part of those half days we had psychotherapy training so it wasn’t extensive but we did discuss psychotherapy.”

“I didn’t receive any form of training other than what we get doing our residency and it came with practice.”

“There was a psychotherapy elective which I think was 3 months long, something like that, I was talking to one of the local psychiatrists who does primarily psychotherapy and she does mixed methods. It was one evening a week.”

Continuing Medical Education (CME): Many participants reported that most of their formal training in the realm of practicing psychotherapy came from CME courses they opted to attend.

“I’ve attended a number of different courses kind of over the years. I probably do some sort of psychiatry update on an average of every 5 years and the last major one I would have gone to was one of the 3-day weekend ones run at place at one of the resorts and that was probably may be 4 years ago.”

Informal psychotherapy training

For many of the participants who practiced psychotherapy on a regular basis, informal training in psychotherapy included: mentorship, peer support, training in psychotherapy prior to medical school, practicing in a shared care model, reading and trial and error.

Mentorship was seen as a facilitator for family physicians practicing psychotherapy:

“Over the years, when practicing in place, I belonged to the GP Psychotherapy Network and then it was part of the mentorship program by the College so we had somebody within the area who was our mentor and then annual conferences, the Collaborative Mental Health Network and then, I did take some courses in CBT about seven years ago.”

“I was lucky enough to land in a practice with other partners who mentored me and I think that piece is also really important in your first 5 years or so of practice, that kind of ongoing mentorship”

Peer support was another important facilitator in the practice of psychotherapy as is evident from the comments below. This peer support was provided by family physicians themselves or by psychiatrists. *“I’m thankful that I have a good network of psychiatrists remotely accessible who will help me stick handle situations in the acute moment so that*

is like most things that I feel that's what has been the most helpful." Another participant stressed the importance of peer support in the community and how lack of support was experienced as a barrier to mental health care.

"I think the biggest problem that we have is access to a psychiatrist when we need it. It was a wonderful thing to be able to have a psychiatrist on the end of the phone for us and I think that that's the biggest problem in community practice is that you don't have the supports when you need it."

Some participants felt that the peer support and relationships were not available and that was a reason for concern for them. I would deem it important to point out that this is related to a tertiary care center and might not be representative of smaller communities where there the medical community may be closer knit: *"I think we don't have, particularly in London, great collegial relationships most of the time with the psychiatrist."*

Training in psychotherapy prior to medical school: Some participants had had some individual opportunities to train in psychotherapy outside of their medical training, or prior to doing medicine, which they found very helpful in their careers as family physicians.

"I started doing psychotherapy based on the business literature and then from there, I started doing CME programs and mentorship programs, the things to kind of built my psychotherapeutic skills and realizing that they're using the same theory but call it different things and then a few different techniques. So it is all kind of built on that and, you know, I actually use psychotherapeutic techniques to look at individual change management in a more business context. So it's, same theory...."

Collaborative care: An important contributor for family physicians practicing psychotherapy was being in a shared care environment and being supported by colleagues.

“A lot of collaborator influences because of psychologist, psychiatrists, mental health nurse, they all have an input so it guides you as to what you are doing is right. Then we have planned discussions, we go to the planned discussions with an idea of what’s going on and then you get input from everyone.”

Reading: Interestingly, reading was something that many participants claimed contributed significantly to the participants’ practicing psychotherapy: *“I have read some articles in the Canadian Family Physician’s Journal about not so much psychotherapy; I think it was maybe CBTs series and then just sort of picking up little things here and there.”*

Experience with time and trial and error were also reported as a facilitators in helping family physicians practice psychotherapy. *“That day-to-day experience gave me the skills on how to start psychotherapy and build rapport with the patient”*

“I guess building on past experiences, you learn as you go, you see how things turn out, you try things, you identify things that didn’t work so well, things that seem to work better, so I guess experience with seeing patients.”

Training needs

With regards to future educational needs, most participants felt there should be more training. The type of training envisioned ranged from more training during undergraduate medical education, postgraduate residency training, more continuing medical education (CME) courses, more hands on and observed training, resource management skills, mentoring and role modeling. More robust teaching during residency seemed to resonate with most of the participants:

“More structure in residency. More structure for sure. Because if I think about it I probably in the end learnt more not from my elective but more from my preceptor, my attending, my supervisor during my core family medicine time. That and following a group of patients longitudinally over the 2-year I think would have been very helpful to help me learn my skills.”

Most of the participants opined that following a few patients and getting feedback on their skills would be helpful to them.

Others felt that regular refreshers in psychotherapy training were needed after graduating:

“I think refreshers here and there would definitely be really helpful, like I said, I just think we need to have these intense doses of knowledge injections or skills injections every so often to keep our interest in clinical medicine it’s helpful for patient care.”

Some participants felt that family physicians should be trained in brief psychotherapy and mixed methods therapy.

“I would keep the competency very basic, you know, pick 1 or 2 or 3 may be some of the brief psychotherapies, you know, that are most useful, and I think most people end up being mixed, I mean especially you’re a family doctor, you become a mixed method person.”

Other things on the wish list included more teaching around pharmacotherapy since there are so many new medicines in the market with different indications for use and different side effect profiles. Participants felt that if they had more training, they would be more likely to do more psychotherapy. One participant summed it very succinctly: *“We need more training.”*

3.3.3.2 Logistical Factors

Time

All the participants in the study felt that lack of time was the biggest barrier for the provision of psychotherapy in their practice: *“Time, probably time is the biggest...barrier to providing good psychotherapeutic intervention.”*

The time available also decreased as some participants’ patient rosters expanded and reached maximum capacity.

“Time is the biggest one. I think previously when my practice wasn’t as busy I would have set aside a morning to do psychotherapy because I was very interested but as the practice has grown or plateaued, now I think time is the biggest issue.”

Psychotherapy is not only time consuming from a practice perspective but also from a documentation stand point, since the counseling or psychotherapy encounter requires detailed documentation. To type up a talk therapy session takes longer than a regular medical encounter, as one physician mentioned: *“I find there is a lot of documentation.”* Participants clearly mentioned that if they had more time they would try to get more training and skills and also be able to see more patients for psychotherapy.

Environment

Most physicians felt that the chaotic and busy family practice environment was not conducive to the practice of psychotherapy. There are too many interruptions, distractions and time issues.

“Just the nature of the office, there are a lot of distractions, so even if you set time aside, there is a knock on the door if there is someone with chest pain calling or, someone walks in with a crying child even if you had scheduled protective time, so family practice is a very chaotic kind of environment.”

Setting aside dedicated time for therapy seemed to be a preference for most family doctors.

“It’s hard to switch gears. You’re not in that listening mode when you treated the asthma and that screening well-baby and then you go into the psychotherapy session. So setting time aside for psychotherapy really helped me because I kind of, you know, talked myself into a place where I was ready to listen and to, you know, to counsel as opposed just fixing the ankles. So it made a difference.”

Administrative issues

Participants reported struggling with where to put their psychotherapy patients in order to least affect the flow of the practice. The agility of the reception staff at triaging and managing scheduling well, was a facilitator to practicing therapy.

“I try to book my psychotherapy patients at the end of the day so that if they are in a crisis then they don’t feel rushed. One of the factors that might be patient limited, is that if patients can’t come at the end of the day and they want to come

earlier, my girls at the front that book those appointments know that I try to avoid booking appointments during the day so they may seek somebody else out if they need an appointment earlier in the day and I prefer to do them at the end of my day.”

Participants also expressed frustration when practicing psychotherapy resulted in them running behind schedule: *“It makes me more likely to run behind schedule.”*

Shared care and resources

Participants reported that the availability of mental health resources in their community impacted their practice of psychotherapy. Physicians who were in a shared care model felt that their patients received better care and they were able to decide who would be the best person to provide the care that a particular patient needed, which streamlined mental health care in their practices. Lack of these services was seen as a barrier, not necessarily to the practice of psychotherapy, but to mental health care overall. In the absence of these resources, participants felt that the family physician was the default person to provide all the care that the patient needed.

“Well the resources available to me have shaped that (practice of psychotherapy) some. We have a social worker who does counseling here and we have a psychiatric liaison on the team that will see and assess patients and patients that are more complex or need longer term follow-up, they’re often able to help facilitate the best place for that person to go to.”

Compensation

Currently, physicians are remunerated by the Ontario Health Insurance Plan (OHIP) in two ways. One is a fee for service model where physicians bill for every patient seen. The codes of mental health care have a prefix “K” prior to them. They are called “K” codes and have a certain amount of money value attached to them. This value is almost twice the value of a regular medical visit for patients. However, one of the requisites for billing the “K” code is that the physician should spend 30 minutes on the visit, 20 minutes with

the patient and 10 minutes for charting. The start and end times need to be documented in order to bill the “K” codes. There are many “K” codes out of which the “K005” is for “mental health” while the “K007” is generally for “psychotherapy”. The K005 code is a commonly billed OHIP code. The second model is the patient enrolled model (PEM) or capitated model where physicians are remunerated for having patients in their practice (regardless of number of visits) and the rate of remuneration is based on their ages (more money value attached to the very young and the very elderly). This model allows physicians to be more flexible with respect to spending more time with the patients that need it.

Participants unanimously reported that their practice of psychotherapy was not affected by the mode or amount of compensation, but was based on patient needs. However, being in a patient enrolled model (PEM) or capitated model of payment did allow them to spend more time to practice psychotherapy.

“I’ve never been driven by remuneration as a reason for doing something, so, I would say no. Certainly with a capitation model, I mean as long as you have the time to do it, it actually, it’s certainly well worth it.”

One participant had some interesting suggestions about the Ontario Health Insurance Plan (OHIP) fee codes that currently allow physicians to bill in 30 and 20 minute increments for psychotherapy:

“It would be nice if it wasn’t just tied to a 20 minute period in 20 minute increments because if you spend 30 minutes with a patient which is the time allotted in our computer model for booking in the computer scheduler, they are either 15 or 30 minutes. We can’t do 20 minute appointments so we book 30 minutes in order to allow enough time, but if the patient actually requires 30 minutes it’s basically 10 minutes of unpaid time, so you still give it to the patient and you do what the patient needs, but it is unpaid service. In that respect, maybe there needs to be a minimum of 20 minutes to say that you can’t really counsel in 10 minutes perhaps, but after that 20 minute period, maybe there needs to be 10 minute allotments, just like other subspecialties like anesthesia bills in 10 minute

allotments, that sort of thing. I have never thought of this before until you asked me this question, but now that I think about it, maybe it devalues the family physician and their time that they spend with their patients because if you spend 30 minutes or if you spend 50 minutes you can only bill for the 20 minute increments and so right now it doesn't affect my practice because if the patient needs 30 minutes they get that, or whatever they need they get it, but it would be nice to be paid for that time that you spend with the patient."

Lack of incentives: Participants opined that the shared care/capitated model of compensation for family physicians might be a dis-incentive for them to personally practice psychotherapy. However, if a social worker or psychologist were available in that health care team, then even though the physician would be doing less therapy, the patient would be benefiting from getting therapy from a skilled person. The following quote captures this dichotomy:

"I do find that fewer and fewer people talk about psychotherapy than they did then and it might be that I more self-selected a group earlier but it just seems to me that is less of a focus of family medicine now. I don't know if that is really the case or not but I do worry that especially with the change in the compensation models, that fewer people will be doing it."

A few participants mentioned that better compensation might provide impetus and incentive for family doctors to engage more in psychotherapy and gain more skills in them: *"It would also be nice if we got paid more because it would be more financially rewarding I suppose. It's not a huge driver though."*

3.3.3.3 Patient factors

Participants were very cognizant how psychotherapy transpired between two people and hence both individuals influence the enactment of the therapeutic process. They recognized that not every patient might be a candidate for therapy, have the patience or time to engage in useful psychotherapy. Participants felt that these factors were a barrier to the practice of psychotherapy. *"Some patients are working and they are not paid if*

they take time off. Those would be the biggest factors. Other times sometimes the patient's willingness. Sometimes they are not ready to open up, so that may be an issue."

Another concern that participants had was that patients could not access skilled therapy in the community due to the costs associated with it. And hence by default, family physicians were left to provide that service to their patients. One participant stated:

"Very few people are willing to go to a psychologist and it's a pretty pricy thing. Yeah, which is really unfortunate because with a lot of mental health issues, people could do well by having somebody who is formally trained, helping them."

Some participants felt that the complexity of mental illness that presents to the office has increased, and that family doctors may be ill equipped to deal with them. *"I tend to find the need is greater, the mix of physical and psycho-emotional complaints is becoming more and more complicated."*

3.3.3.4 Personal Factors

This sections explores how family physicians feel about psychotherapy: the pros and cons of therapy, family physicians' motivation to provide psychotherapy to their patients, the participants' concerns about the practice of psychotherapy in their discipline and gender issues in psychotherapy.

Pros and cons of practicing psychotherapy

Another aspect of the study was to understand how practicing psychotherapy affected the physician as a person and as a clinician. A minority of participants said that it did not affect them in any way, *"I don't know if it makes me feel one way or another really."*

Others described how practicing psychotherapy had some pros and cons.

Pros of practicing psychotherapy: Some participants felt that it made them better physicians, more humane and better listeners. One participant said:

“I think that you become a better physician in general because you are listening better, not only because are you listening more but listening better, because you have gained some extra skills in the area and I think you will be a better help to your patients because you are more understanding and you are willing to sort of stick around, you know, longer with them and not get impatient and simply dismiss you know their or interrupt their lack of adherence as their disinterest and just sort of give up on people.”

Other participants felt that practicing psychotherapy brought about personal growth, heightened their cognitive awareness and insight.

“From a personal level, hearing their stories has made me reflect a lot on my own life. You see parallels between lives and you think, how can I change my life to avoid this situation that my patient has now found himself or herself in? Or when someone loses a loved one and they are distraught, we all know that we are all going to lose loved ones and it just reinforces for me how valuable family is and I think that makes me change the way I live my life personally so it hopefully helps me take advantage of the moments in my life that maybe I wouldn’t have seen the value in if I didn’t hear others people’s suffering and stories.”

Practicing psychotherapy also improved the therapeutic alliance: *“I feel that it benefits me as a physician because I will have a better understanding of them and it will improve our therapeutic alliance because we deal with other unrelated issues.”*

Some participants felt that practicing psychotherapy was integral to the philosophy of comprehensive family medicine where we see the patient from a holistic point of view instead of just the biomedical perspective. *“I think it enriches your practice because I think that it is such a big part of that, that concept of the whole person.”*

“In psychotherapy...it is a time that you have carried people through a crisis. They will always remember that but it is not the gratitude part, it is the part of having formed that bond, so it definitely enriches. I mean, the lowest common denominator of practice could be that you see people for concurrent illnesses and that probably gets you through but it doesn’t really make it a rewarding practice. So I think it is rewarding.”

Another advantage of practicing psychotherapy that was discussed was better delineation of patient-physician boundaries. One participant explained, *“Makes me more aware of*

myself, my surrounding and the need for appropriate boundaries in my relationships, for sure, both at work and at home.”

Cons of practicing psychotherapy: By far the most common disadvantage to doing therapy reported by participants was the “emotional baggage” and “decentering” that was associated with hearing patients’ stories.

“The downside is that I think you need to have a healthy sort of balanced life in order to do it because peoples’ life experiences and some of the facts of trauma are difficult to deal with so I think that you need to have a healthy balance.”

Another family physician stated: *“ I don’t think I could do a full day of it. I find it tiring and I think most therapists do.”*

Some participants admitted to being frustrated in psychotherapy due to multiple reasons. One reason was lack of physician skills. *“Frustrated because I feel that I’m not, I can’t cater to my patients’ needs because of my lack of experience.”* Also lack of improvement in patient health could be frustrating. *“There are some people that are so chronic and never seem to get better and I find that frustrating despite a good therapeutic relationship over many years, they just don’t seem to move on and get better.”*

Concerns about psychotherapy

Participants were very open and candid about their concerns about the practice of psychotherapy in family medicine and the main themes are described below.

Lack of resources at the primary care and specialist levels: Participants highlighted the worries they had about the diminishing resources that are available for mental health care. This was at multiple levels: at the 1) institutional level, 2) specialist level and 3) community level.

1-At the institutional level, participants expressed concerns regarding resources in the community: *“There have been fewer patients in hospital, fewer beds, more cared for in the community.”*

2-At the community level, lack of enough family physicians was a concern: *“There is more need for family physicians to follow patients more actively and there’s not enough family physicians.”*

3-At the specialist level, the concern was inadequate access to psychiatrists: *“I think with resources since I have been in practice in psychiatry, they have declined”.*

Gender issues in psychotherapy

The analysis revealed that most male participants did not feel that the gender of the physician played a role in the practice of psychotherapy as is evident by the following statement: *“It has a lot more to do with personality type and what you’re able to use and kind of deal with so, you know, I am who I am and that’s what I find interesting, and therefore, I do.”*

Yet most female participants believed that gender did have an influence, be it the gender of the therapist or of the patients.

“ I feel that for myself as a female physician, my practice style is in kind of a feminine way in that I do sort of respond very much emotionally to my patients and that there is sort of maybe a little bit of that nurturing sort of role that I think lends itself to you know, in wanting to sit down and talk things out and sort of provide that sometimes lengthily supportive conversation. I think that women sometimes when they tend to do that with each other much more so than men with each other or even men with women. In terms of if my patient were female or male, I feel like I would be equally inclined to provide them with psychotherapy sort of depending on their own preferences.”

Another interesting fact to note is that most female participants in our study did not feel that their training had prepared them for the practice of psychotherapy whereas their male

counterparts felt otherwise, however, there were more female participants in the study could have influenced the findings.

Motivation to continue providing psychotherapy

Personal beliefs/philosophy of family medicine: Participants felt that the motivation to provide psychotherapy for their patients was inherent in them as physicians and was in keeping with the spirit of family medicine, continuity of care and holistic care. Here are some representative quotes: *“Nothing external. I think my motivation comes from inside.*

It comes from my beliefs about what family practice should be.”

“The patients I provide psychotherapy to are the patients I know and so my commitment to them as their physician for the last 20 odd years is probably what will keep me in the game. I mean it’s sad to see when somebody is in crisis but also having developed that relationship over the years makes it easier to be the supportive person that can give them a new perspective.”

Better communication with specialists and allied mental health professionals: Participants said that if they had the support of specialists and psychologists, they would feel more confident practicing psychotherapy and working as a team:

“Family doctors are a good resource and I am very lucky that I have a psychotherapist that is working in our facility. We need to make the affiliations in our teams. There is an availability of the psychiatrist on an as needed basis, psychotherapist that works wonders because I am working in such a place where all of this is available and I think that there is a huge learning potential there so I think that, yes; they should be a part of family medicine.”

Patient needs and patient physician relationship: The biggest driver for family physicians practicing psychotherapy was patient needs and the patient physician relationship. The participants provided whatever skills they had to help their patients in need. *“The need. Just that patients have a need and it’s not easy to send them to someone somewhere else so that if especially they are in crisis”*. Continuity of care and the strong patient physician relationship was seen as a big facilitator for providing therapy.

“Because you know these patients well, probably the amount of time you take is altered by that. I mean, if you have a longstanding patient who becomes depressed you already know a lot of their history, so, you know, it doesn’t mean that you don’t need to be with them and don’t need to see them with some frequency but there is a lot of information that you already know before you embark on anything more formal with them. So, that continuity obviously, that history that you have with them, plays a very rich role I think, in terms of any kind of mental health issues that they develop.”

Having learners: Some participants mentioned that having learners and needing to provide them with a role model in the provision of psychotherapy, was their driving motivation. *“I think having residents around would be one because, you know, my feeling that it is useful so I would want to teach them some of the basic skills.”*

3.4 Discussion and conclusion

General discussion

The data from the study provided a general understanding about psychotherapy practiced in family medicine. Family physicians reported that they practice psychotherapy, yet there also seemed to be some confusion about what is psychotherapy. For example, family physicians generally provided unclear definitions of psychotherapy, such as equating psychotherapy with counseling, compared to definitions in the literature. Other information provided by participants would suggest that they may be actually practicing a combination of counseling, guidance, advice and education. This does not constitute psychotherapy in the true and formal sense. This is also in keeping with the fact that most physicians bill the “K005” code, which is “mental health” and not psychotherapy.

The study suggests that most family physicians receive limited training in psychotherapeutic skills. This is substantiated in the literature as well.(14)(15)(16)

Teaching in psychotherapeutic education was reported to be inadequate in both

undergraduate and post-graduate medical education, although a number of participants reported seeking CME training, mentorship, peer and interdisciplinary training to augment their knowledge and skills. The majority declared a need for more training, but paradoxically, some also reported being satisfied with their training and in their ability to provide psychotherapy to help their patients. Interestingly, there seemed to be some gender difference with a greater proportion of females feeling that they were not trained and hence would benefit from more training, compared to the male family physicians who felt more confident in their training. Whether this was due to differential training received by males and females, a sampling artifact or actual differences in self-perception is impossible to assess in this study.

Importantly, family physicians indicated that they provided psychotherapeutic services based on patient needs and the patient-family physician relationship, despite their more limited psychotherapeutic skills. Comments by the participants suggested that they embraced the foundational principles of the patient-physician relationship and comprehensive family medicine; as such they felt internally motivated to care for their patients' body and mind.

The factors that affected family physicians' practice of psychotherapy, namely lack of time, lack of conducive environment, lack of training and administrative issues, were brought up by the participants as barriers to practicing psychotherapy and are consistent with the literature.(2)(14)(15)(17) There are limited resources in the community with respect to access to psychiatrists, psychologist/social worker care and peer support systems which is supported in the literature.(18) Those family physicians who reported working within Family Health Teams or in a shared care model, had access to psychiatric

and psychotherapeutic services and felt that their patients were well served. Interestingly, some family physicians felt that this would take away from them doing psychotherapy, while others felt that they would feel more confident of practicing it since they would have peer support. Most family physicians, who had access to trained psychotherapists, felt their patients could receive good mental health services while still remaining in contact with their family physician. They themselves felt confident in treating mental illness in the community and this finding is supported by extant literature.(19)

There is an inherent implication in these findings that family physicians appreciate that their patients are served better when they receive psychotherapeutic services from professionals who are trained psychotherapists. Furthermore, this also suggests that physicians see themselves as having a central role in the management of patients in a team collaborative care environment. According to the Canadian Community Health Survey results from 2003(20), 62.9% of adults older than 15 years with a measured mental health disorder in the past 12 months in Canada did not consult anyone for their illness. Out of the 37.1% who saw someone for their illness, 26.5% consulted with their family physician, 8.6% saw a psychologist, 10.3% saw a social worker, 12.0% saw a psychiatrist, 3.9% saw a religious advisor and 3.1% saw a nurse. The majority of patients with mental illness in Canada will see their family physician as a first point of contact with the health care system. However, a large percentage of people with mental illness remain uncared for. This trend is also seen in Australia and hence their team based primary mental health care, called Best Access, which includes psychotherapy provided by professional psychotherapists, is delivered in the community with family physicians having a central role.(19)

The patient-family physician relationship is very strong and effective. The literature suggests that therapeutic alliance, good communication and empathy are key variables that help patients achieve good outcomes in psychotherapy or talk therapy.(21)(22)(23)(24)(25) This might be the reason why there is some literature showing effectiveness of family physicians' psychotherapy outcomes.(26)(27)(28) However, Atkins and Christensen argue, that the therapeutic alliance may provide benefit in early intervention but over time, therapist skills are needed to sustain treatment.(29) This discussion then raises the question: how much training in psychotherapy do family physicians in Ontario need? Do they need it at all if they are working in shared care models where they have access to trained psychotherapists? Some studies have found that paraprofessionals, that is, persons not highly trained in psychotherapy, had generally equivalent patient outcomes compared to trained psychotherapists.(29)(30)(31) However, trained therapists do better with patients experiencing more severe illness.(29)(32) Clinical expertise, training, communication(33) and patient factors all contribute to psychotherapy outcomes.

Most of the interviewed family physicians had an appreciation of the mind and body connection and believe that the practice of psychotherapy is important, much needed and rewarding work and would like to see psychotherapeutic skills taught over the continuum of undergraduate, post graduate and continuing medical education. So perhaps the scope and nature of psychotherapy needs to be different in primary care. It could be more focused on brief psychotherapies such as motivational interviewing, solution focused psychotherapy, and modified CBT, which would provide family physicians with some skills in psychotherapy.(17) Some training is necessary if family physicians are to be

adept at recognizing mental illness and assessing patients for psychotherapy readiness. They are in a unique position for early identification of, and hence prevention of mental illness. Davidsen posits that this area warrants attention because the number of patients with emotional problems seen by family physicians is so large that even a small improvement in psychological management skills would have great population effects.(14)

Not all family physicians in Ontario, however, practice within Family Health Teams or shared care models; thus, some basic skill set in psychotherapeutic techniques is necessary for them to provide good mental health care to the patients they serve, if they do not have access to specialized resources.

Conclusion

Family physicians are providing psychotherapy to their patients based on patient needs, despite not being adequately trained in psychotherapeutic skills. More clarity and consensus around the definition of psychotherapy among different trained therapists and physicians is needed. This will aid in evaluating psychotherapy outcomes and its research in family medicine. Professionals trained to be psychotherapists can provide more effective psychotherapy to patients with mental illness, and yet their services are not covered by the OHIP. Family Health Teams and similar collaborative care models in Ontario have government funding to hire social workers and psychologists to provide therapy to patients in that team. Our participants described being more satisfied when practicing within Family Health Teams and how patients benefit from having insured psychotherapy services. However, the majority of family physicians in Ontario do not practice in a Family Health Team. Therefore, they become the providers of

psychotherapy by default. There may or may not be adequate community psychotherapy resources and/or patients may not have the financial resources to go to a trained psychotherapist. This generates inequity and a “two tiered system” in mental health service provision, as only 40% of Ontarians have access to a family health teams.(34) This leads us to query the principles and ethical and moral basis of Ontario’s health policy pertaining to mental health in general and psychotherapeutic services in particular. The following chapter reviews recent policy documents in Ontario with respect to psychotherapy.

3.5 Study limitations

This is a qualitative study and hence the findings may not be transferable. This study was limited to family physicians in Southwestern Ontario and did not reflect Ontario’s diverse family physician population; hence some issues or themes that are specific to some populations may have been missed. The sample included more female participants that may have impacted the findings, however, this does reflect the changing demographic in family practice in Canada.

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Chapter 4

4 Mental Health and Addiction: analysis of recent policy documents in Ontario with respect to psychotherapy

4.1 Introduction

Governments are the ultimate stewards of mental health and as such they are responsible for ensuring priorities are “set among mental health needs, services, treatments and prevention and promotion strategies, and choices made about their funding”.(1)(p.87)

These complex activities are carried out through the development and implementation of policy. “Policy identifies the major issues and objectives, defines the respective roles of the public and private sectors in financing and provision, identifies policy instrument and organizational agreements required in the public and possibly in the private sectors to meet mental health objectives, sets the agenda for capacity building and organizational development, and provides guidance for prioritizing expenditure, thus linking analysis of problems to decision about resource allocation.”(1)(p.87)

Policies are developed in three ways: 1) rational-comprehensive; 2) successive limited comparisons, and 3) mixed-scanning model.(2)(3)(4) The rational-comprehensive model follows a logical and ordered sequence of policy making phases. In this model the policy analyst scans, assesses and compares all options, calculating all the social, political and economic costs and benefits of a public policy. The main principle is the collection and analysis of all data. This is intended to provide policy-makers with certainty. The second method is also called “incrementalism” or “muddling through” and was put forth by Charles Lindblom in 1959. In his conception, policy-making is viewed as iterative, in which policies are gradually modified. He posits that policy makers are generally

conservative in decision making and that policy is generally a matter of muddling through. Time and lack of resources limit comprehensive research with the aim of informing the policy making process; therefore, policy choices emerge out of a succession of comparisons among a limited set of options. The mixed-scanning model is the third decision making framework in which decision-making is done in different layers. Simplistically, it is a combination of the rational-comprehensive and incrementalist models. Mixed scanning also contains rules for allocation of resources among the levels of decision making and for evaluation leading to changes in the proportion of higher versus lower levels of scanning based on changes in the situation.(5)(6) All three methods have different pros and cons and are applicable to different policy formulations.

Policy formulation should provide a clear articulation of values and an action blueprint for the realization of the values. Yet, Brownson et al. indicate that there are many barriers to the development and implementation of good health policies. Often conflicting values, insufficient evidence or poorly understood evidence, vested interests and other challenges can thwart good policy formulation.(7) As Ishiyama and Breuning posit, policy formulation is often influenced by political processes at the cost of overlooking compelling, objective logic of the facts, evidence, and information collected.(8)

In the past 20 years in Ontario and in federal contexts bearing upon Ontario, there has been a wealth of documents in the area of mental health policy. Included are positions advanced by different local and national governments, ministries, mental health professionals' associations and mental health and addictions organizations. Almost none of these documents have included specific attention to the issue of psychotherapy, one of

the important treatment components for persons with mental illness. There are good reasons for that as mental health policy documents do not routinely explore the nuances of every particular treatment modality. Policy positions more often explore the general principles, values and goals of a system of mental health care that are meant to guide the choice of treatment modality. Yet policy documents should frame the context for the provision of government services and as such identify a blueprint under which services are to be provided.(9) Policy documents provide information on governmental foci and priorities that as yet shall become apparent, but also contradictions in values and principles and in the actual blueprint for provision of services. Thus, policy analysis (evaluation) is critical to understanding the contradictions and whether or not the policies were implemented and actually improved outcomes.

The contention here is that by considering the more fine grained particularity of treatment modality – in our particular case, the practice of psychotherapy – the more general principles, values and goals of a system of mental health care can find a more powerful implementation platform. Principles can be better applied; values can be more clearly expressed; goals can be more plausibly achieved. As will be argued here, a more considered approach to psychotherapy has the potential of furthering the goals of much of the mental health policy documents advanced in the past 20 years.

Policy Analysis

Full evaluation of evidence-based policy includes the assessment of three domains, process (defining the problem and understanding approaches to improve likelihood of adoption), content (identification of specific policy options and comparison of options

likely to be effective) and outcome (evaluation of policy impact).(2)(10) In essence, a full evaluation examines whether the policy made a difference in outcomes. Yet Duncan and Reutter have identified limitations with this traditional approach to policy analysis which entails “deductive evaluation of the relative merit of various policy proposals.”(11)(p.244) They stress the importance of stepping back and dissecting the actual policy documents within a “critical theory approach”. Specifically, they posit that problems and policies are social constructs. As such, critical policy analysis focuses on exposing “the ideologies and values underlying policy issues and their proposed solutions”.(11)(p.244) This analytic approach examines what is included in the policy debate; importantly it also examines what is excluded and not discussed in the policy documents. Critical policy analysis examines the interplay of how the processes and contexts influence how particular policy problems are defined (content), described and circumscribed and what policies are chosen. It “exposes the reality of organizational processes, particularly as they relate to how policies are experienced by people in their daily environments.”(11)(p.244) Peter et al. have expanded on Duncan and Reutter’s work by developing a methodology for conducting a policy analysis to examine not only content, ideologies and values underlying policy issues, but also ethical implications for the policies.(12)

4.1 Purpose of the study

The purpose of this study is a policy document analysis through the examination of Ontario’s mental health policy documents within the context of the provision of psychotherapy. The analysis is guided by the critical theory approach of Duncan and Reutter as described above(11), and the qualitative policy analytic methodology of Peter

et al.(12) Their methodology includes three forms of analyses: descriptive, conceptual and normative.(12)

The Descriptive Analysis provides an overall, unadorned gestalt view of the reviewed policy documents.(12)

The Conceptual Analysis clarifies and makes explicit the values, principles and assumptions within the policy documents. Peter et al. elaborated on this by saying, “that conceptual analysis is employed to sort out the various meanings of key concepts and to unpack terms loaded with values and questionable assumptions. It is a useful method in policy analysis because policy has an irreducible moral dimension insofar as it involves a decision about how to act towards affected others who are not involved (or directly involved) in actually deciding what to do about an identified problem. The moral dimension may not be readily visible but can be made visible through the analysis of underlying assumptions and values”.(12)(p.1628)

Values present what is important. In the political and policy contexts, they reflect beliefs about goals and virtues that social institutions want to represent. These virtues are reflected in the institutions’ actions and processes. Values, however, can be contradictory. For example the value of respecting the autonomy of an individual with mental illness can conflict with involuntary commitment of an individual with mental illness to prevent harm to the individual or others. The challenge then becomes to prioritize values in order to attain the best policy to achieve the desired goals.(12) In this study the values and goals that potentially underpin the practice of psychotherapy in Ontario are elaborated.

The Normative Analysis is described by Peter et al. as “an examination of the values and principles with respect to the values that ought to direct policy and practice”.(12)(p.1632) Although there is not a strict format for the normative analysis, the values and principles chosen from the descriptive and conceptual analyses can help inform recommendations for health policy. In this section I will critique the values and principles identified through the conceptual analysis to see if they are congruent with the principles that ought to influence the proposed mental health policy with regards to the provision of psychotherapy in Ontario. I will also compare them with the ground realities portrayed in the literature. As Duncan and Reutter point out, this critical analysis also exposes the reality of organizational processes, particularly as they relate to how policies are experienced by people in their daily environments, i.e. the ground realities.(11)

4.2 Methodology

The methodology used for this study is qualitative policy analysis. Descriptive, conceptual and normative analyses were used. The descriptive analysis presents a description of documents reviewed within the context of psychotherapy and what is said about psychotherapy and its provision in Ontario. The conceptual analysis focuses on values, principles and assumptions presented in the policy documents within the context of psychotherapy. For the normative analysis, the data were analyzed to see if the end point or goal envisioned was congruent with the values and principles; if so what steps were suggested for the realization of those goals?

4.2.1 Data

A number of new policy documents have been put forward in the last five years in Ontario, Canada. Many national and international jurisdictions have revised and presented mental health policies following the publication of the World Health Report by the World Health Organization (WHO) which called for better mental health care.

A purposeful total sample of 22 key provincial policy documents on mental health, published between 1993 to 2014, and other documents including stakeholder discussion papers, reports, guidelines and position papers were collected for the study. Although most of the documents are recent (dating back to 10 years) there were some older foundational documents that were helpful in understanding the evolution of mental health policy in Ontario. Some of the documents shown below in Tables 1 and 2 were chosen based on how much they most clearly influence the delivery of psychotherapy. Ten of these documents represent institutions. Institutions refer to the structure and processes used by governments to deliver public policy such as legislation, regulations and guidelines in determining how services are to be funded.⁽¹²⁾ While institutions do not solely determine policy outcomes, they consolidate the power of certain ideas and interests and structure conduct. The provinces and territories have a responsibility to decide which and to what extent health services, outside the Canada Health Act (CHA), such as psychotherapy, are publicly funded.

The remaining two documents are national homecare reports and discussions papers (Table 2) that represent ideas and interests. Ideas represent the beliefs, values and knowledge that shape a policy field, while interests refer to those groups who are in a position to influence policy choices.⁽¹²⁾ These policy documents were chosen because

they are highly influential national reports that critique the current Canadian system and provide policy recommendations with the purpose of improving healthcare services including psychotherapy.

Table 1

Policy documents, Guidelines, Reports, Recommendations and Discussion papers (Ontario unless stated otherwise)

- 1-One of five themed papers commissioned by the Ontario Government by an advisory group of people with lived experience of mental illness. *Ontario mental health and addictions strategy: creating healthy communities*. (2010)
- 2-Ontario's comprehensive mental health and addictions strategy: *open minds, healthy minds*. (2010)
- 3-Canadian Mental Health Association. *Advice to the minister of health and long term care: developing a 10-year mental health and addictions strategy for Ontario*. (2011)
- 4-A position paper by Nick Kates et al., developed by the Canadian Psychiatric Association and the College of Family Physicians of Canada collaborative working group on shared mental health care and approved by their respective boards. *The evolution of collaborative mental health care in Canada: a shared vision for the future*. (2010)
- 5- Canadian Mental Health Association, Ontario division. *Summary of older adults mental health and addictions invitational forums*. (2012)
- 6- Ontario Public School Boards Association-goal statement: *Children's mental health Ontario*. accessed June 2014 (2014)
- 7-Ontario Medical Association statement. *The time to strengthen care for patients with mental illness is now: Ontario's doctors*". (2011)
- 8-Mental Health Commission of Canada. *Changing directions changing lives: the mental health strategy for Canada*. (2012)
- 9- A multiple stakeholder institutions discussion paper submitted to the selected committee on mental health and addictions. *Addressing integration of mental health and addictions*. (2010)
- 10-Ministry of Health Ontario. *Putting people first: the reform of mental health services in Ontario*. (1993)
- 11-Addictions Ontario, Canadian Mental Health Association Ontario, Ontario Federation of Community Mental Health and Addiction Programs and Center for Addictions and

Mental Health. *Opening doors in primary health care: strengthening the interface between mental health and addictions service providers and primary health care, final report.* (2010)

12-Centre for Addictions and Mental Health, Public Health Ontario and Toronto Public Health. *Connecting the dots: how Ontario primary health units are addressing child and youth mental health.* (2013)

13-Canadian Mental Health Association, Ontario. *The windows of opportunity for mental health reform in Ontario.* (2010)

14-Government of Ontario. *Making it happen: operational framework for the delivery of mental health services and support* (2001)

15-Advisory Group to the Minister of Health and Long Term Care. *Every door is the right door: towards a 10-year mental health and addictions strategy. A discussion paper* (2009)

16-Legislative Assembly of Ontario. Final Report of the Select Committee on Mental Health and Addictions. *Navigating the journey to wellness: the comprehensive mental health and addictions action plan for Ontarians* (2010)

17-Ontario's Comprehensive Mental Health and Addictions Strategy. *Support every child reach every child. Update on Minister of Education's initiatives and setting the stage for years 4+ of the strategy* (2013)

18-A federal-provincial-territorial partnership. *Mental health strategy for corrections in Canada* (2009)

19-Mental Health Commission of Canada. *Towards recovery and wellbeing. A framework for a mental health strategy for Canada* (2009)

20-Canadian Psychiatric Association and the College of Family Physicians of Canada. *Shared mental health care in Canada: current status, commentary and recommendation. A report of the collaborative working group on shared mental health care.* (2000)

Table 2 **National homecare report**

1-Canada Standing Senate Committee on Social Affairs, Science and Technology. (2002). *The health of Canadians – The federal role. Final report on the state of the health care system in Canada. Volume six: Recommendations for reform.*(Chair: The Honorable Michael J. L. Kirby). Ottawa: Author

2-Commission on the Future of Health Care in Canada. (2002) *Building on values: The future of health care in Canada – Final report.* (Commissioner: Roy.J. Romanow).

Ottawa: Commission on the Future of Health Care in Canada (Cat. No. CP32-85/2002E-IN)

4.2.2 Data extraction

Once the documents were selected, a semi-structured data extraction guide (see Appendix 9) was used to extract data relevant to the research question. The semi-structured data extraction guide was created using a similar methodology as Peter et al. used in their study.(12) One of the four researchers in my study is an expert qualitative researcher and content expert in mental health and psychotherapy, another is an expert on policy analysis and evaluation and content expert in health policy, the third is a political scientist and content expert on mental health policy in Ontario. These researchers lent their expertise in constructing the data extraction guide.

4.2.3 Data Analysis

Three researchers then reviewed the data independently. All the themes pertaining to the research question were identified and the data were coded. The reviewers met regularly to compare and corroborate themes and findings and this iterative process continued until all possible values and principles in these papers were extracted and saturation was reached. The findings were then analyzed descriptively, conceptually and normatively.(12)

4.2.4 Trustworthiness and Credibility

There are many aspects of trustworthiness and credibility in qualitative studies. These include reflexivity (technique whereby the investigators turn the focus back on themselves in order to appraise their influence on the findings and analysis), depth of description, accuracy and rigor, intellectual honesty and a willingness to explore alternate explanations and interpretations.(13) These requirements were ensured by each

researcher independently reviewing the data, taking field notes and having all three researchers conduct the final descriptive, conceptual and normative analysis together. The interpretation of the content from the data that had consensus of the majority of the researchers was deemed accurate and used in the study.(14)

4.3 Results

4.3.1 Descriptive Analysis

The descriptive analysis found very sparse mention of psychotherapy in the documents that were reviewed. Psychotherapy is explicitly mentioned in only one document, the National Mental Health Strategy for Canada titled, Changing Directions, Changing Lives, which was presented by the Mental Health Commission of Canada:

“There are some publicly funded psychotherapies and clinical counselling in Canada in hospitals and mental health centres, but the waiting lists are very long and the criteria to access these services can be very restrictive. There are therapists and counsellors in private practice, but many people cannot afford them, and not enough is being done to fund and support innovative, team-based approaches to providing these services in community mental health and primary health care networks. Given the potential benefits across the lifespan, it is especially urgent for governments to address the problem of ‘two-tier’ access to psychotherapies and clinical counselling in the area of child and youth mental health. It is not acceptable that young people whose families cannot afford to pay for privately delivered services should be made to wait for up to a year for publicly funded services. Governments must ensure that there are no financial barriers for children and youth who need timely access to psychotherapies or clinical counselling. (15)(p.61-62)

“Other services for which we know people are waiting too long if they can get it at all, are psychotherapies and clinical counselling. There is strong evidence that these services, when provided by those who are qualified to deliver approaches that are based on the best available evidence, are cost effective and improve outcomes for many people living with mental health problems and illness. Publicly funded systems in countries such as Australia and the United Kingdom have made expanding access to these services a priority.”(15)(p.6-62)

In other documents psychotherapeutic services were mentioned implicitly (underlined below) and embedded under the broader rubric of management of mental illness or mental health services needed in the community.

“Implement positive psychology programs in the school system that address resilience and strength based approach to solving problems”(16)(p.25)

“When young people have highly complex needs, an equally highly skilled team of counselors linked to the schools is there to provide support 24 hrs. a day, 7 days a week for them and their families.(but there are no such provisions for adults and generally in the community)”(15)(p.27-28)

“The following list is intended to highlight the range of supports and services in a comprehensive system. Health Promotion/Education, Housing, Income Supports and Services, Peer Supports, Self-Help and Alternative Supports Drop-Ins, Vocational and Employment Programs, Consumer-Run Businesses, Family Supports, Social/Recreational Programs, Primary Care Physicians, Health Service Organizations, Community Health Centers, 24 Hour Crisis Telephone Lines, Mobile Crisis Teams, Safe Beds, Schedule 1 Emergency Services, Inpatient Services, Outpatient Services, Intensive Case Management, Assertive Community Treatment Teams, Mobile Outreach Teams, Residential Treatment Facilities, Specialized Forensic services (there is no mention of what treatments are to be provided – rather again very broad headings) and this is a document that is supposed to aid in actual implementation of the mental health services.”(17)(p.54)

There is no mention of access to psychotherapeutic services, quality of services, competence of therapists and who is fiscally responsible for provision of psychotherapy or the institutional infrastructure needed for its provision.

The descriptive analysis also revealed that the provision of psychotherapy is a provincial responsibility and is dispersed across numerous programs and ministries with no single structure for policy implementation and accountability. It is prescribed as per local demands and needs in Ontario. For example, the Ontario school board explicitly mentions having incorporated counselors for early detection and intervention of mental illness in

children and youth. Addiction services and public health units also have counselors and therapists for specific mental health diagnoses. However, there is no explicit mention or recommendations for psychotherapy in the treatment of mental health in the community for both primary care and tertiary care. This finding was very surprising, considering many of the experts who sat on the policy committees were psychologists, though it is probable that either the committee mandate was to not discuss specifics of treatment approaches or content was edited out.

4.3.2 Conceptual Analysis

The values and principles in these documents paint a picture of a preferred future state of mental health care in Ontario. The goals are very broad based and have few details on implementation, evaluation or attention to local needs.

The envisioned health system is underpinned by all the tenets of the Canada Health Act (CHA)(18) which are equity, accessibility and quality of care. Sensitivity to culture and marginalized peoples is made a priority. The assumption agreed upon is that people with mental illness have full autonomy to access help for their illness and they and their families are supported throughout their journey. Mental health is delivered in an integrated manner and is patient-centered so that care is continuous and seamless across the spectrum of services, client ages and disease progression. The workforce is skilled, competent and patient-centered and is adept at working in collaborative environments. Primary care is robust and like a “home” where people with different skills can work together to ensure prevention and early detection of mental illnesses and can provide best management for people with mental illness. Primary care is collaborative in that family physicians and psychiatrists can work together to manage moderate to severe mental

illness. Use of technology, like telepsychiatry, is identified as a way to reach patients in remote areas and to service all marginalized groups of people including northerners. The reports promote research and teaching in academic units to ensure professionals are competent and there is a continuous evaluation of different outcomes of the mental health system that leads to perpetual improvement. Research is being conducted at both an academic and administrative levels to inform future directions. The whole government is involved and all ministries and institutions work towards eradication of the stigma of mental illness in society; poverty reduction, housing and employment will be made a priority. People with mental illness are included and incorporated in day to day life and in the process of implementing the mental health goals. Other institutions such as work places and correctional facilities, incorporate wellness programs and ensure that people are free of mental illness and if afflicted, do not suffer silently. All this is being done in the community with specialized services and acute care services, like hospitals, being accessed for severe illness that is not manageable in the community.

The values and principles that are relevant to the practice of psychotherapy are as follows: 1) treatment in the community as ideal; 2) equity, justice and access (CHA principles); 3) emphasis on the individual; 4) peer support; 5) family support; 6) prevention of mental illness and promotion of wellbeing; 7) integrated service and collaborative mental health care, and 8) professional competence and service accountability.

4.3.2.1 Treatment in Community as ideal

The policy documents conceptualize home and community treatment of mental illnesses as ideal. This approach is more natural, cost effective and promotes overall wellbeing and

inclusion of people with mental illness into society. However, community resources are not sufficient and hence jails and correctional institutions become the new day institutions for many individuals with mental illness who cannot access the resources they need to function well.(19) One document summarized this very well:

“A transformed mental health system should primarily be based in the community, because obtaining services, treatments and support in communities improves quality of life and leads to spending less time in hospital. Deinstitutionalization; when Canada, along with many other countries, moved away from a long tradition of warehousing people with mental illness in institutions (or ‘asylums’), it was the right policy. Our failure was in not replacing institutional care with sufficient services and supports in the community”(15)(p.60)

Even people with severe mental illness, such as schizophrenia, can be managed well in the community by interdisciplinary teams and many successful programs in the community are a testament to that. However, acute intensive psychiatric care in hospitals is also needed and needs to be balanced with community resources.

4.3.2.2 Equity, Justice and Access (CHA principles)

The values and principles that embody the Canada Health Act loomed largest in all the mental health policy documents and were stressed upon in nearly every chapter of every document reviewed. The values of equity, justice, universal access and inclusion were deemed an integral and necessary part of any mental health policy or program moving forward, nationally and in Ontario as well.

“Everyone in Canada should have the opportunity to achieve the best possible mental health and well-being. Currently, that opportunity does not come equally. Simply put, people with—among other things—better incomes, more education, and stronger social networks tend to be healthier. In Canada and around the world, the importance of addressing such disparities in order to improve health and social outcomes, including mental health outcomes, is increasingly recognized. Canada’s Ministers of Health and Health Promotion have acknowledged that disparities in health exist and promised that, “where they can

be changed, we will work together with our partners in and outside governments to try to reduce or remove such differences.”(15)(p.80)

“Too many people from the immigrant, refugee, ethno-cultural and racialized communities that make up a large part of Canada’s population do not have access to services, treatments and supports that feel safe and are effective because they are attuned to that group’s culture, experience and understanding. People from diverse backgrounds can have different values and traditions that inform their approach to health. They sometimes experience and describe mental health problems and illnesses differently, which can be challenging for service providers”(15)(p.84)

“The needs of consumers which pertain to age, gender, sexual orientation, limitations and/or challenges (physical, developmental disabilities, medical issues), language, culture, race, economic standing, creed, education, past or present experiences (substance abuse, sexual abuse, violence, homelessness, involvement with the forensic system, etc.) will be incorporated into service delivery.”(17)(p.6)

Specifically looking at access to mental health services in general and psychotherapy in particular, the general values at work are that access to services should be universal.

“Although one in five Ontarians will have a mental illness or addiction, only one-third access services. About 75% of children with mental health disorders do not receive specialized treatment”(20)(p.16)

“The mandate is to provide access to the right combination of services, treatments and supports, when and where people need them. A full range of services, treatments and supports includes primary health care, community-based and specialized mental health services, peer support, and supported housing, education and employment. Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners”(21)(p.104)

“We have to ensure that people of all ages have timely access to appropriate and effective mental health programs, treatments, services, and supports in their community, or as close as possible to where they live or work, regardless of their ability to pay. The mental health system is centered on fostering people’s mental health and meeting the full range of people’s needs – however complex – in the least restrictive way possible. It is seamlessly integrated within and across the public, private, and voluntary sectors, across jurisdictions, and across the lifespan. The pressing needs in under-serviced areas such as the north are addressed”(21)(p.6)

These excerpts recommend integrated community based mental health services and psychotherapy/counseling would be one of them, albeit implicitly suggested. The poor access to psychotherapeutic services in Ontario are in direct contrast to the values and principles of equity, justice and universal access, making the status quo, with respect to psychotherapeutic services, unacceptable.

4.3.2.3 Emphasis on the individual

The documents conceptualized that the emphasis of mental health policy and action plan should be on the individual with mental illness. This was envisioned to be done in two ways. The first is to provide patient-centered care and empower the patient with mental illness be involved in his or her decision making for health (personal autonomy). The second is to involve people with a lived experience of mental illness, in all walks of life, and involve them in the process of carving out mental health services delivery to ensure that these services cater to patient needs.

“Person-directed care is effective. People who receive person-directed care: are more satisfied with their care, feel more empowered, have fewer symptoms, require fewer tests, have more trust in their providers and the system”(20)(p.30)

“While many mental health and addiction services are person-centered, the lived experience of people with a mental illness and/or an addiction is not always valued or respected. Programs are often designed to meet providers’ needs rather than the needs of people who use services (e.g., hours of operation, how appointments are scheduled).”(20)(p.17)

“People with serious mental illness will achieve greater independence; that is, the ability to live in the community with the least intervention from formal services and to the greatest extent possible, make their own decisions.”(17)(p.54)

The principle of personal autonomy and incorporation of people recovering from mental illness into society in a meaningful way was a fundamental theme in all the policy documents.

4.3.2.4 Peer support

Most policy documents proposed that people with lived experience who are on their way to recovery or have recovered can provide invaluable support to the people who currently suffer from mental illness. There are recommendations in most policy documents to incorporate peer support groups in mental health and addictions services and programs. However, there are no concrete recommendations on how to incorporate peer support workers into the mental health care system.

“Peer support works because people who have experience with mental health problems and illnesses can offer support, encouragement, and hope to each other when facing similar situations. Peer support can be offered wherever people need it—at peer-run organizations, workplaces, schools or healthcare settings.”(15)(p.72)

“The state of Victoria, Australia is considering creating “consumer and carer peer worker roles” to assist others in navigating the complexities of the mental health system. Employing people with lived experience, the peer worker or navigator roles would provide assistance in both primary and specialist care settings.”(22)(p.15)

4.3.2.5 Family support

In most of the policy documents, families were seen as the central force in propelling people with mental illness towards wellbeing and before that, in nurturing the individual and providing a safe-haven that is instrumental in preventing mental illness. When individuals suffer and are cared for in the community, families will bear the brunt of caregiver burden and need to be supported during these times with compassionate time off, respite care, navigation support etc.

“Families are critical to the development of a child’s mental well-being and future resilience in life. Recognizing that, many strategies focused on public health programs that encourage healthy pregnancies, pre and post-natal support programs, education on parenting skills and visiting nurses for first-time families. Family and other care-givers can play a valuable role in early detection, intervention and follow-up for their loved one. While balancing confidentiality

and privacy, all jurisdictions are taking measures to include care-givers as partners in decision-making for treatment plans when desired by the person with mental illness. If agreed, care-givers must have access to information, education and guidance so that they are supported in their efforts to help. To that end, the Mental Health Commission of Canada (MHCC) urged the creation of “Family Navigators” to assist families in their role as mental health partners. These “Navigators”, along with other providers, would help families through the maze of services and decisions that present themselves when confronted with the problems posed by mental illness. The state of Victoria, Australia is considering the implementation of Care Coordinators to assist consumers and their care-givers in performing this exact function, crossing all portfolios (e.g. housing, employment, education, mental health, social work) necessary for recovery. The MHCC recommended that family needs should be met by providing respite services, assistance with day-to-day caregiving responsibilities, support for the family members (including emotional support) and income support when family members cannot work due to caregiver responsibilities.”(22)(p.16-17)

The focus on the family and its involvement in the care of the individual is particularly apt with regard to youth and adolescents, but also for adults as well. Families can sometime become the enablers or triggers for decompensation in individuals with mental illness.

4.3.2.6 Prevention of mental illness and promotion of mental well-being

The health care system is currently designed to treat mental illnesses when they arise and escalate. However, most policy documents advocate for strategies for prevention of mental illness. This can be done in part by actively screening for mental health problems in primary care using validated tools each time a patient is seen at his/her family physician’s office, but on a larger scale by implementing societal strategies:

“The reviewed strategies all agreed that biological, economic, social, situational and psychological factors combust to produce mental well-being or mental health problems. Typically no one factor is the sole contributor to the onset or severity of an illness. As a result, governments are focusing more attention on the benefits, both morally and financially, of improving “upstream” social and environmental factors that promote mental health and prevent illness. Workplaces can either be places that promote mental health or

be the cause of significant mental and emotional distress. Jurisdictions have equated the financial impact of workplace absence due to mental health problems in the millions of dollars annually. Recognizing the important economic benefits to society and companies, many governments have embarked on initiatives that encourage public and private enterprise to become good “quality of life” employers. Psychotherapy services can be useful for early identification and de-escalation of mental health problems. An example is England: “Approved funding for the IAPT (Improving Access to Psychological Therapy) to increase access to low and high intensity therapy teams for people with mild to moderate mental health problems.”(22)(p.16)

The concept of prevention and health promotion is crucial in decreasing the burden of mental illness downstream when it is more costly and difficult to treat. Momentum is building to promote the prevention of mental illnesses of Ontarians as well as efforts to improve treatment options and services for children and youth with mental health illness. The aim is to identify mental illness, or those children and youth who are at risk for developing mental illness, early and taking the right steps to improve long term outcomes. For instance, the Ontario government is focusing the first three years of the 10-year plan on child and youth mental health. In addition to addressing improvements to clinical services, this strategy acknowledges the need to promote resilience and mental wellness. Prevention and mental health promotion is one of the fundamental values in the Ontario mental health strategy.

4.3.2.7 Integrated services and Collaborative mental health care

Mental health and addictions services have historically been delivered separately, in “silos”, from other health services, such as family health care, acute care, emergency care and long-term care. Moreover, mental health and addiction services have been and are still currently being delivered by different ministries. This makes it difficult for people and families to navigate the health system and access all the services they need. It can

also lead to gaps, unnecessary duplication or the inappropriate use of services. This redundancy calls for an integrated approach to mental health care. Integration can be defined as “actively managing all elements of the continuum of health and care services required by individuals and communities in order to achieve a seamless care pathway for the individual or client group (NHS, Dept. of Health, 2001).”(23)(p.2)

“Integration of mental health and addiction services takes place at different levels: Integration can (and should) take place at the policy level to ensure that eligibility criteria, financial incentives, workforce requirements and the like are in place to support the other forms of integration that can be implemented. Of great importance is that integration improves the ability of service providers to meet the needs of their clients/consumers in a coordinated, cost-effective, evidence-based and accessible manner. Client-centered integration can occur at the clinical level, organizational level and service delivery level. There is no single answer to how integration should occur. Benefits of integration: There are three main areas of benefit in an integrated mental health and addictions system: continuity of care, coordination of services and efficiency. Both continuity of care and coordination of services should lead to better client experience and clinical outcomes. Clients’ experience with an integrated system should improve as a result of more streamlined and coordinated service delivery. Clients would have better continuity of care and be less likely to fall through the cracks. An integrated system should lead to better clinical outcomes due to more of a focus on prevention, better service provider coordination of client information as well as additional opportunities within the system to share information. Efficiencies would occur in two ways, better client outcomes should lead to lower hospitalization rates and use of acute services and the sharing of organizational resources such as human resources and information technology supports. Improved integration of mental health and addictions services is no panacea. Many people with mental illness and addictions – and particularly those with concurrent disorders – will require a range of health and social services, so it is unlikely that one system or care or service could ever encompass all their needs.”(23)(p.2-3)

All the provincial and national policy papers have pointed out the gap in and need for integrated services in mental health and a lack of strategy or framework to implement integration. There is uncertainty about what integration should look like and how it should be achieved. In an older provincial policy in the early 90s, next steps were given to the Ministry of Health and Long Term Care, Ontario to develop a provincial planning

and implementation guide, to refine labor and reallocation strategy and develop key service ratios.(24) It seems from the most recent policy documents that there was no implementation on that recommendation.

Some documents recommend the provision of a “core basket of services” for people with mental illness, to ensure them some basic services. The contents of this basket are not clearly articulated and contain broad categories based on the social determinants of health (housing, employment etc.). There is no mention of specific items, such as access to medications or psychotherapeutic services. Other documents examine who needs to take ownership of implementing integration and recommend that promoting integration is the responsibility of the Local Health Integration Networks (LHINs), which are the health authorities responsible for regional administration of public healthcare services in the province of Ontario. However, most documents are consistent that more provincial and federal direction is necessary. One document suggests an overarching governance structure to oversee the implementation of these integrated services.

“The Select Committee was struck by the observation that no one person or organization is responsible for connecting these various parts, or “breaking down the silos” as we so often heard. There is also no single organization responsible for ensuring that mental health and addictions services and supports are delivered consistently and comprehensively across Ontario. The Select Committee therefore recommends, 1. A new umbrella organization – Mental Health and Addictions Ontario (MHAO), responsible to the Ministry of Health and Long Term Care – should be created and to ensure that a single body is responsible for designing, managing and co-ordinating the mental health and addictions system, and that programs and services are delivered consistently and comprehensively across Ontario. All mental health and addictions programs and services – for all regions of the province and for all ages, including children and youth - should be consolidated in the Ministry of Health and Long-term Care.”(25)(p.3)

“Both Ontario reports recommend a basket of core services be identified and provided to bring additional capacity into the system. Those seeking mental health and addiction services often require an array of additional supports, such as income support and housing. Building a responsive and coordinated system to accommodate the breadth of service needs can be challenging within the current

service delivery systems, which are designed on disparate ministerial, departmental and functional structures. Access to a comprehensive range of services and supports is urgently required. The Select Committee's recommendation that 'a basket of core institutional, residential and community services is available in every region of the province' is to be commended."(25)(p.14)

Integrated mental health and community services is seen as a core value that is needed to ensure seamless and effective services for Ontarians with mental illness. Hence all policy documents are advocating for a "whole of government approach" for its realization.

We found that the policy documents regarding interprofessional collaborative care recommended that the locus of collaboration occur at the service delivery level:

"Collaborative care is care that is delivered by providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual support. As in any effective partnership, common goals, clear and equitable decision making, and open and regular communication are key."
(26)(p.2)

There is ample domestic and international evidence that shows benefits for collaborative care in both the short and long term. This has been measured by symptom improvement, functional improvement, reduced disability days, increased workplace tenure, increased quality adjusted life years and increased compliance with medication.(26)(27) The cost-effectiveness of collaborative care programs has also been well established.(26)

However, initial investment and education needs to be made in order to reap the benefits downstream. There are many models of collaborative mental health care and the documents included some very successful examples from around the province. Any activity that enables mental health and addictions and primary care providers to work together more effectively to improve the care they deliver can be collaborative.

"The role of the family physician in providing mental health promotion, screening, early detection and treatment and appropriate referral to specialized services is not discussed in these documents. Similarly, a number of documents discuss the issue of discharge from specialized, often regionally based services,

back into the community but fail to outline the role of the family physician in providing follow-up care. These activities are critical to the successful care of individuals and to the successful functioning of the mental health care system. The fact that mental health services do not figure prominently in reform planning is concerning, in light of the high prevalence of mental health.”(28)(p.6)

“The family physician already plays an extensive role as a provider of mental health care in almost every community in Canada. In theory, the family physician and the psychiatrist are natural partners in the mental health care system. While neither may be able to meet every need of a patient with a mental disorder, each can offer complementary services, which enables them to play a key role at different stages of an episode of illness and the subsequent period of recovery. Too often, however, family physicians and psychiatrists fail to establish the collaborative working relationships that would strengthen the role of the family physician, enhance the consultative role of the psychiatrist, and improve the quality of care their patients receive. The need to improve these relationships, a key step towards a better-integrated and more efficient health care system, becomes even more pressing in the current climate of rapid change in the organization of health care in Canadian provinces. (The need for interface between psychiatry and family medicine are recognized – this will bolster treatment in primary care and improve access and quality of care by family doctors for their mentally ill patients).”(29)(p.1)

Interestingly, most collaborative mental health care literature is focused around the family physician and the psychiatrist. Other professionals and allied health workers do not feature in the literature. The role of psychologists, social workers, psychiatric nurses, nurse practitioners, youth workers etc. and their role in collaborative mental health care is missing. It is implicitly captured in discussion of team based shared care where services are rendered by social workers, psychologists, psychiatrists, family physicians and other health care providers,

“Many Family Health Teams (FHTs) have incorporated mental health and some have incorporated addiction services in the range of programs they provide. The development of service agreements and protocols between the FHTs and community mental health and addiction providers would strengthen inter-sectorial linkages.”(30)(p.22)

There are many excellent collaborative mental health care models or shared-care models across the province, country and internationally. We can learn from them and integrate

them in our health care system. Some of these will be discussed in the normative analysis section and in the conclusion and recommendation section.

4.3.2.8 Professional competence and service accountability

Values around the mental health work force are also espoused in the documents. They conceptualized a work-force that is competent, able to work collaboratively, is patient-centered, anti-stigma and efficient. Again, there was no specific mention of psychotherapists and counselors as an essential part of the mental health workforce but encompassed all professionals under the umbrella of mental health work force.

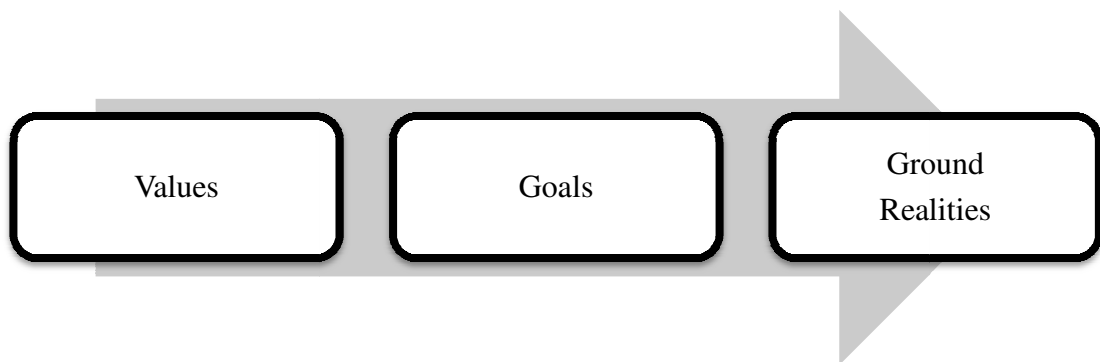
“There are many dimensions to promoting the development of a mental health workforce that has the right people with the right skills in the right places. The mental health workforce is highly complex, consisting of regulated and unregulated direct care providers, as well as administrators and educators. Human resources represent roughly 80 per cent of direct care spending on mental health problems and illnesses. A pan-Canadian workforce education and development strategy could enable the development of core competencies common to all mental health professional disciplines, shape interdisciplinary training guidelines, and help to build bridges to other sectors. In addition, such a strategy could create opportunities for people living with mental health problems and illnesses to take up positions at all levels of the mental health workforce.”(15)(p.126)

Most people will see their family physicians as the first point of contact for any mental illness, so having family physicians with good psychological skills is essential. The documents that addressed competency recommended that the academic Departments of Family Medicine and Psychiatry train physicians to not only be competent in managing mental illness but also be adept at working in collaborative environments.

“Family physicians are more likely to be comfortable participating in the mental health care of patients with psychiatric disorders if they have adequate knowledge about these disorders, and the skills to work collaboratively with psychiatrists. Consequently, the Working Group identified continuing medical education (CME) as an important factor in the successful implementation of shared mental health care.”(28)(p.12)

4.3.3 Normative Analysis

Normative analysis involves the examination of the identified values, concepts and assumptions with respect to the values that ought to direct policy and practice.(12) The values and principles evident to the team reviewing the policy documents pertaining to psychotherapy have been elaborated in the conceptual analysis section. In the normative analysis section I will compare and contrast these values with the basic values that are generally aspired to in any Canadian health care system, namely: 1) values of health care ethics and 2) the Canada Health Act. The natural culmination of values and principles should be goals or targets set by health policy. I will also compare the goals set by the policy documents and how they compare to the ground realities or how they are experienced by people in their daily environments.



The values of health care ethics are: 1) patient autonomy, which is a person's ability to make a choice without coercion; 2) beneficence, which is to act for the greater good; 3) non-maleficence, which is to cause no harm, and 4) justice, which is the equitable distribution of services and goods, regardless of a person's status. The Canada Health Act is federal legislation that puts in place conditions by which individual provinces and territories in Canada may receive funding for health care services.(18) The Act includes

the following principles: 1) Public Health Administration which states that all administration of provincial health insurance must be carried out by a public authority on a non-profit basis, subject to regular audits; 2) comprehensiveness which means that all necessary health services, including hospitals, physicians and surgical dentists must be insured; 3) universality, which means that all insured residents are entitled to the same level of health care; 4) portability which means that a resident that moves to a different province or territory is still entitled to coverage from their home province during a minimum waiting period, and 5) accessibility which means that all insured persons have reasonable access to health care facilities.

Psychotherapy is an integral part of the treatment of mental illness.⁽³¹⁾ Two of the core values of the Ontario mental health policy documents, as elaborated in the conceptual analysis, were equitable access to mental health services and treatment in the community, which aligns with the Canada Health Act and health care ethics. However, these values and their resultant goals are not fulfilled when it comes to the provision of community psychotherapeutic services in Ontario. Psychotherapy is insured when provided in hospitals or if provided by psychiatrists or family physicians. Sometimes other health care professionals, such as social workers, nurses and psychologists, funded by other funding mechanisms and/or Ministries, e.g. public health units, Child and Parents Resource Institute (CPRI), Madame Vanier Institute, can also provide psychotherapy, although long wait lists often exist for these services. Otherwise, outpatient psychotherapeutic services can only be accessed by individuals paying either out of pocket, personal health insurance, Workplace Safety and Insurance Board (WSIB) if

therapy is related to work related trauma, or if the patient has access to national Employment Assistance Program (EAP) which covers limited counseling sessions.(32)

The fees for these psychotherapeutic services in Ontario vary from \$35 per hour to \$300 per hour depending on the qualifications and experience of the therapist and geographical regions.(33)(34) The average hourly rate is \$150.(33) Depending on the presenting mental illness, therapy usually entails multiple appointments for complete treatment. This can result in huge therapy costs. Ontarians also have access to insured psychotherapy or counseling services by psychiatric nurses, social workers and clinical psychologists through family physicians who are part of a Family Health Team and/or available through some hospital clinics on an outpatient basis. Family Health Teams are a primary health care model where physicians are paid per capita for enrolling patients in their practices. The Ministry of Health and Long-term Care (MOHLTC) provides fiscal support for allied health professionals to serve the needs of the patient population in the Family Health Team. These allied health professionals for example can be dietitians, occupation therapists, nurse practitioners, psychologists, social workers etc., based on patient population needs. The government introduced Family Health Teams in 2005 to strengthen health care at the grass roots level and to improve access to other services such as occupational therapists, social workers, dietitians, etc. There are approximately 200 Family Health Teams as of 2010 serving millions of Ontarians, which is approximately 40% of the provincial population.(35) Although, this model improves access to psychotherapeutic services for patients with mental illness, it is only available to less than half of Ontarians and generates a disparity in the supply of insured services. Even though the values in the health policy papers recommend equity and universal access, access to

psychotherapy in Ontario is neither universal nor equitable. The implementation of Family Health Teams is an achievable goal but has not become a ground reality universally, and that is partly due to economic reasons.

Family Health Teams require a significant financial investment. The marriage between values/principles and cost benefit analyses influences the funding for different services, as well as the availability of funds. There is only a cursory mention of the cost and benefits of implementing mental health reforms and none relative to psychotherapy.

There are good examples of mental health reforms on a national level in Australia and the United Kingdom and their financial reports and evaluation reports can help set the economic agenda for mental health reform implementation in Ontario. There are specifically no data available in the documents, on public and private psychotherapy expenditures in Ontario or Canada. These costs are hidden in the numbers presented for overall mental health expenditure.

A research study in the Canadian Journal of Psychiatry in 2008 entitled, “Expenditures on mental health and addictions for Canadian Provinces” concluded that, “Canadian public mental health spending is lower than most developed countries, and a little below the minimum acceptable amount of 5% stated by the European Mental Health Economics Network.”(36)(p.307) The study examined data for general hospitals, psychiatric hospitals, fee for service physicians, community mental health centers, pharmaceuticals and addiction services. The study showed that per capita expenditures ranged from \$230 (2003/04) in British Columbia to \$138 in Saskatchewan. While the Canadian per capita average was \$172, Ontario spent only \$152. Provincial community mental health expenditures varied from \$17 per capita to \$64 while Ontario’s expenditures were \$27

(Canadian average was \$43). For addiction services Ontario spent \$10 per capita compared to the national average of \$13. More so there are substantial inequities across the province depending on where a person lives. For example in 2007, funding for community mental health services ranged from \$19 to \$123 per capita across Local Health Integration Network (LHIN) areas.

“The cost of preventing and treating mental illnesses and addictions is only a fraction of what these illnesses cost society in lost productivity and other social costs. In fact, investing in, and actively supporting people to stay mentally healthy saves money. Every \$1 spent on mental health and addictions, saves \$7 in health costs and \$30 dollars in lost productivity and social costs.”(20)(p.16)

“There should be no doubt that achieving the kind of transformation that is needed for mental health will take money, and that Canada will need to increase what it spends on mental health as a share of overall health and social spending. Canada spends considerably less on mental health than several comparable countries, with only just over seven cents out of every public health care dollar (seven per cent) going to mental health. This is far below the 10 to 11 per cent of public health spending devoted to mental health in countries such as New Zealand and the U.K.”(15)(p.126)

“In the recent past, the use of performance indicators in mental health service provision has not been as prevalent as those in other areas of health and participation by consumers and caregivers was not considered to be informative to the evaluation process. A review of the strategies showed that there has been a trend to change this. For example, Australia established the “National Mental Health Performance and Benchmarking Framework” in 2006. From this, “Key Performance Indicators” (KPI) were developed for services provided across the age spectrum in the public sector. Future plans intend to extend the KPIs to include the private sector and non-governmental organizations.”(22)(p.24)

This lack of fiscal responsibility and accountability for enacting the mental health reform makes it difficult to implement change and the ground realities do not change for patients in the community. The values laden mental health and addictions strategy needs to be connected to the political and business machinery that can provide the funds, resources and impetus to enable equitable implementation of change. It is laudable that the policy

documents have given enough leeway for jurisdictions to implement strategies based on local context and needs. However, this flexibility can become a two edged sword; too much flexibility will result in lack of consistent services across the province.

Another set of values from the conceptual analysis includes emphasis on the individual, family support and prevention of mental illness and health promotion. These values are in line with the value of beneficence or the greater good to ensure optimal health and wellbeing for Canadians. With proper medical support and psychotherapy, individuals with mental illness can be supported before their mental illness becomes more severe. Psychotherapies have been shown to be cost effective in the long term in preventing long term disability and in health care savings.(37) However, due to the inconsistent access to therapies, these values cannot be implemented universally in the Ontario. The value of beneficence or the greater good cannot be applied. This is an example of how the values and principles of equity and access are intertwined with other values or principles. In order for psychotherapeutic treatments to benefit families and promote wellness and prevent mental illness, they need to be universally and equitably available to all Ontarians.

Professional competency and service accountability was considered an integral part of a mental health policy in Ontario. Competent and knowledgeable work force is the foundation of an efficient mental health care system and competent psychotherapists are needed to provide psychotherapy. This value is in alignment with the value of non-maleficence (do no harm) of the health care ethics. The policy documents call for competence in the mental health workforce. We see from the recent proclamation of the Psychotherapy Act 2007 on April 1, 2015, and the formation of the CRPO, only

professionals meeting strict training and credentialing criteria will be able to practice psychotherapy and be called psychotherapists. Findings from some of the policy documents and from chapters 2 and 3, suggest that family physicians are not trained to provide psychotherapeutic services. They need more training in psychotherapeutics. A basic level of training in psychotherapy is needed for the early diagnosis and management of mental illness in the primary care setting, before patients can appropriately be referred for specialist psychotherapy. This limited training is in contradiction to the values aspired in the policy documents and in the general values of health care ethics to do no harm. The goals for improving competence in psychotherapy will require dissemination of these goals and values and communicating with the academic and research experts in medical education to mobilize them to enact this change. Some of this change is already happening with the introduction of guidelines for the practice of psychotherapy by physicians who are not psychiatrists. These guidelines have been put forth by the General Physicians Psychotherapy Association in Canada in 2010.(38) More stakeholders need to be approached and their buy-in is needed to ensure that envisioned changes are implemented across the board. The CPSO and the CRPO need to collaborate and define the scope of practice by family physicians with respect to psychotherapy. Also, evaluations of the implementation will be needed to assess process and context and outcomes for patients.

The values of patient empowerment and autonomy are in synchronicity with the CHA principle of universality, and comprehensiveness. However, we note again that due to the lack of universal availability of insured services, even if patients were autonomous, many would not have the option to choose psychotherapy services if they could not afford it,

unless they had other access through private insurance or to physicians or limited number of other professionals providing psychotherapy in publicly funded organizations.

However, psychotherapy is not the only management option available to patients so its impact on patient autonomy may be minimal.

In summary, the values and principles framing the recent mental health policy documents are all lofty but congruent with the principles and values of health ethics and the CHA.

The lack of access in psychotherapy is an implementation issue, not an ethical one.

However, it is one main barrier in the realization of improved primary mental health care.

Universal access needs to happen before the other values and goals of mental health reform can be implemented. However, there is no mention of an implementation strategy or evaluative plan in the documents. Also there is no planning and projection of costs of implementing the mental health strategy nationally and provincially, which makes it difficult to produce a blueprint for change.

4.4 Discussion and conclusion

While there are many policy documents on the transformation of mental health and addictions care in Ontario and Canada with lofty values and goals, there is currently no clear system to ensure universal access to quality psychotherapeutic services to all Ontarians, nor is there a clear implementation or evaluative strategy.

The respective governments, political and business machinery need to elaborate a concrete implementation and evaluation strategy. As we have seen above, one example of improving access is already in place in the form of Family Health Teams.

The transformation of primary health care across the province has meant that about 40 per cent of the population now has access to Family Health Teams which have a range of health care providers including psychotherapists. This model needs to be expanded to include all Ontarians. The interdisciplinary team based primary care leads to the promotion of well being, and the provision of support for people to manage their own health; hence, this has a role of empowering them. Moreover, the whole family is supported. Finally, the staff has to be competent to meet indicators set by the Ministry of Health and Long Term Care. Mental health and addictions systems are also being increasingly integrated. These developments are creating opportunities for improving the integration of mental health and primary health care and better collaboration between multiple professionals.

The recommendation to support and expand mental health within Family Health Teams is supported by the evidence from the case studies, “Improving Access to Psychological Therapies” (IAPT) program in the United Kingdom (UK) and the “Better Access” program from Australia. They provide us with good examples and comparisons on which to base Canadian and specifically Ontario’s psychotherapy initiative.

IAPT is an initiative to improve access to insured psychological therapies through the United Kingdom’s publicly funded National Health Service (NHS). It was a result of the economic evaluations by Professor Lord Richard Layard and Labor Party policy that was implemented in 2006/2007. The aim of the project was to increase the provision of evidence-based treatments for anxiety and depression by primary care organizations in a stepped care approach; high intensity psychotherapy for moderate to severe mental illness and less intense or phone therapy for milder mental illness. The treatment approach is

based on best available evidence for psychotherapy and on the National Institute of Health and Care Excellence (NICE) guidelines. The IAPT program involves workforce planning to adequately train the required mental health professionals. The IAPT is an independent entity with its own structure that is accessible through physicians and by patient self-referral. Initial indications show that the project has resulted in good clinical outcomes and is cited as a good example of the use of stepped-care to disseminate cognitive behavior therapy and other psychotherapies.⁽³⁷⁾⁽³⁹⁾ The IAPT cost benefit analysis and pilots projected huge benefits and savings downstream and data are beginning to be analyzed from the first few years of the program. This suggests that psychotherapy is worth the investment. The NICE guidelines and research are exemplary in the world. They provide evidence based data that is available on psychotherapy techniques and provide a format for application to primary mental health care.² These guidelines and evidence based research can be used by the Ontario policy makers to guide their endeavors.

In 2007 the Australian federal government instituted the “Better Access to Psychiatrist, Psychologists and FPs through Medicare Benefits Schedule (Better Access) Initiative”. This program has more in common with the Ontario Family Health Teams model of primary care. This program increases access to private psychologists by making them available on heavily subsidized rates through the publicly funded Medicare Benefits Schedule. The psychologists are co-located with family physicians. The program enables a patient to receive up to 12 sessions of evidence based mental health care from

² The IAPT is being adapted for implementation in Chiba, Japan, and the preliminary evaluations have shown promising results.

registered providers, when his/her family physician, in consultation with the patient, judges such services to be of benefit. The family physician retains his or her role as the provider of continuing care, with psychologist feedback to the family physician and a progress review midway in the sessions.(40) This exemplifies collaborative mental health care or shared care much in the same way that is possible within Ontario's Family Health Teams. This program also creates connections between family physicians and psychiatrists which is also possible within the Family Health Teams. We live in the age of technology; collaboration in primary mental health care is possible by many means, like tele-psychiatry and e-consult system.

These case studies are examples of action taken by two developed nations to improve the mental health of their citizens by implementing psychotherapeutic services. The discussion on cost benefit analysis and long term benefits are outside the scope of this thesis, but the general message is clear. Psychotherapeutic treatments are important in comprehensive primary mental health care and need to be implemented in Ontario. Our Family Health Teams are already working towards shared mental health care. They could be expanded and supported to recruit the right workforce and can be the first step towards integration, collaboration and evidenced based care with the potential for evaluation and improvement as the administrative support machinery is already available within Family Health Teams. Another option could be to strengthen and expand already existing community mental health agencies and develop a collaborative framework for them and family physicians.

At the very minimum, I recommend a core basket of clinical mental health services be made available to all Ontarians. The three main services should be: clinical care by a

physician to manage both mental and physical illnesses; a psychotherapist for support and therapy, and availability of psychotropic medications. Although universal access to other services such as housing, employment and other determinants of health is needed and recommended, these three core services should be a mandatory provision for everyone with mild to moderate mental illness in Ontario.

Finally, I recommend that more collaboration in practice and research be organized by Departments of Family Medicine, Psychology, Social Work, Nursing and Psychiatry etc., to make collaborative primary mental health a focus of health care policy in Ontario and Canada.

4.5 Study limitations

The findings of this study would have been more robust and rich, if the opinions and perspectives of various actors (e.g., patients, families, psychiatrists, family physicians, counselors, educators, government), with interest and a stake in the mental health policy, would have been included. However, that would have been outside the scope of this thesis. The ground realities were extracted from the literature available and hence reflect what has been written: it may be slightly different from the actual state of mental health care in the community. This study predominantly used documents from Ontario, and thus a comparative study of mental health policy in other jurisdictions would have provided comparative data with respect to context, content and process of different health care policies.

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Chapter 5

5 Discussion and Conclusion

5.1 Introduction

The global burden of mental health is enormous from a human as well as economic perspective.(1)(2) Most mental illnesses are treatable and preventable. Psychotherapy is an effective component in the management of mental illnesses along with psychotropic medicines and psychosocial rehabilitation.(3) In Ontario, Canada, psychotherapy is practiced by non-medical professionals, including psychiatric nurses, social workers, and psychologists, as well as by medical professionals, namely psychiatrists and family physicians. However, not a lot is known about psychotherapy in family medicine. From the patients' perspective, access to psychotherapy is not universal and equitable in Ontario. Health policy and how it is implemented influences access to psychotherapy. Other factors such as clinical expertise, training, economics and political will, influence the delivery of health services in which psychotherapy is our area of interest.

5.2 Integrated summary of findings

When findings of both studies are compared, some common themes emerge, which are: 1) role of family physicians in the prevention and treatment of mental illness; 2) family physicians' training in psychotherapy; 3) a strong case for provision of psychotherapy within primary collaborative mental health care in Ontario; and 4) future directions for primary mental health care in Ontario.

5.2.1 Role of family physicians in the prevention and treatment of mental illness

There is much momentum pushing towards an improvement in primary mental health care. The WHO set a mandate to strengthen the provision of primary mental health care services in the community in 2001.(4) The cost effectiveness of treating mental illness in the community has been well established in the literature.(3) The study on health policy reveals that most national and Ontario mental health and addictions policy papers are calling for more mental health services to be delivered in primary care. Family medicine is a large and integral component of primary care. From the qualitative study we observed that family physicians are treating a full spectrum of mental illnesses in their daily practices and are providing some form of psychotherapy on a regular basis. However, the role of the family physician in this scenario and in shared care models is not clear. They are not expert mental health specialists such as psychiatrists, nor are they trained psychotherapists who are psychologists, social workers or psychiatric nurses. What then is the most appropriate role for the family physician in primary mental health care?

Almost 63% of Canadians do not see a mental health provider for their mental illness.(5) However, of the Canadians who do seek help for their mental illness, the majority will see their family physician as the first point of contact for mental illness.(5) In Canada 50% of patients receiving treatment for their illness receive care only from their family physician.(6) This places family physicians in an advantageous position for the early diagnosis of mental illness and to limit or prevent mental illness from becoming severe. This can be achieved by using evidenced based objective screening tools in daily practice

to actively screen for mental illness. The family physicians interviewed in the qualitative study felt that their patients received better mental health care when there were trained psychotherapists and other allied mental health workers working alongside with them in a team based environment. They felt confident in their own abilities to manage mental illness when they had access to a psychiatrist and other resources in the community which is commensurate with findings in the literature.(7) The mental health policy papers also advocate for collaborative practice in primary mental health care. These findings imply that family physicians view themselves as having a nuclear role in primary mental health care. They perceive themselves as providing medical, including mental health care to their patients, but also having the ability to access specialized care for them, based on patient needs. Family physicians do not appear to view themselves as the mental health “expert”. The family physician role in Ontario’s primary mental health care may be similar to the role of family physicians in the Australian model of collaborative community mental health care called “Better Access”.(8) In this model, family physicians have access to insured psychiatric and psychotherapeutic services, but are the main managers of their patients’ mental and physical health. This enables family physicians to provide continuity of care to their patients with mental illness, and the patients’ families, across their illness trajectory.(9)(10) Another potential model is based on the IAPT model UK. This model is rooted in shared care but not co-location. The IAPT program is a separate entity from the family physician’s practice. Patients can self-refer or be referred by other physicians. IAPT is a publicly funded organization in the community comprising of different professional psychotherapists. In this model, patients are triaged into different categories based on the severity of their mental illness. They are then assigned to the

therapist that will most suit the patient's psychotherapy needs.(11) However, in this model, patients still need to be followed by their family physician or a psychiatrist for their psychopharmacotherapy needs. A model similar to this could work well in Ontario; however, it would require the implementation of a separate organization across the province. The IAPT is currently being evaluated for implementation in Japan and in Australian emergency rooms.

Family Health Teams in Ontario already have the infrastructure to provide and sustain mental health services including insured psychotherapy by professional psychotherapists. Family Health Teams also have allied health professionals who can provide case management, if needed. Case management is an important element in ensuring that, not only mental health, but all aspects of health care for a patient within the team work seamlessly. Expanding Family Health Teams might be the most cost effective and relatively easier way to integrate mental health services into primary care. However, not all family physicians work in shared care models in Ontario and depending on where they practice, may be the only mental health expert available to their patients. This makes it imperative that family physicians have a certain level of competency in managing mental illness. The literature shows that a significant percentage of family physicians do not diagnose or treat mental illness well.(12)(7) However, a majority of them express interest in learning how to diagnose and treat mental illness well, and can be trained.(7)

5.2.2 Family physician's training in psychotherapy

It was clear throughout this thesis that family physicians are not well trained in conducting psychotherapy and this is supported in the literature.(13)(14)(15)(7)(12) In the qualitative study, most family physicians professed to practicing psychotherapy but

could not describe in detail what they did. The training they received was both heterogeneous and did not include any formal psychotherapy teaching in their undergraduate and post graduate medical training. The skills they used were gained based on heuristic principles. However, paradoxically, about 50% of family physicians were satisfied with their training. Alternatively, we saw in chapter 2 the robust training requirements by other professional bodies before their members can practice psychotherapy. Psychologists require a doctoral degree and many hours of supervised training. The training requirement for social workers, counselors and psychotherapists is equally robust. Compared to the above-mentioned professionals, family physicians' training is certainly very limited. However, family physicians are permitted to provide psychotherapy as per the College of Physicians and Surgeons of Ontario.

The criteria to practice psychotherapy in Ontario and to use the title of psychotherapist, is being set by the nascent CRPO. This College came into formal existence by the proclamation of the Psychotherapy Act of 2007, on April 1 2015. (16) It is the official body that will regulate all professionals who call themselves psychotherapists. The premise for the genesis of this college is to prevent harm to patients by therapists who are not well trained. Physicians may or may not be required to be registered with this College; however, they will not be able to practice psychotherapy unless they meet the criteria set by this College. The optics of how physicians in general, and family physicians in particular, will fit into this registration process is yet to be determined.

Some pertinent questions arise from this paradoxical situation. First, should family physicians be registered with the CRPO? If so, they will require a certain level of training to be able to fulfill the requirements for professional therapists. Is the time and effort

needed for such robust training necessary when we already have trained psychotherapists available to provide good care to patients? If it is not, then should family physicians be doing psychotherapy at all? Perhaps, they should be providing alternate forms of psychotherapy which could be tailored for application in family medicine, like attentive listening, Motivational Interviewing or psychoeducation.

Data from the interviews with family physicians shows that most participants expressed a need and desire for more training in psychotherapeutic skills. The General Physicians Psychotherapy Association in Canada has come up with guidelines in 2010 for the practice of psychotherapy by physicians who are not psychiatrists. Most of their recommendations are in line with what the family physicians wished for in the qualitative study, i.e. more formal training in psychotherapy throughout the continuum of undergraduate, graduate and continuing medical education.⁽¹⁷⁾ These guidelines also lay down other general rules for the conduct of therapy and are a very timely document that needs to be implemented throughout family medicine training. Competency in diagnosing and managing mental health in general, and psychotherapy skills in particular, is much needed by family physicians. The prevalence of mental illness is rising and family physicians need to be competent in diagnosing and managing mental illness to a certain extent, since they are the first point of contact. They can prevent mental illness from worsening and become a catalyst for change in patients by engaging them in therapy, connecting them with the right resources and empowering them.

The second question that arises is whether psychotherapy by family physicians is or should be different? Whether there should be a focus on change-theory-based therapies, such as Motivational Interviewing. The nature of psychotherapy in primary care has been

debated in the literature in the last decade and “brief psychotherapies” in the treatment of mental health have become popular.(18) They are defined as therapy that typically end by 25 sessions.(19) Although there is substantial literature available on brief psychotherapies in primary care, the majority of it is conducted by psychologists and/or psychiatrists. Hence the effectiveness of these therapies with family physicians as the psychotherapist is unknown. Alexander et al. systematically reviewed studies on brief psychotherapies tailored for primary care and suggest that they are effective in the treatment of multiple mental illnesses.(18)(20)(21). Thus, implementation of these techniques is still challenging, as family physicians will need to be trained in them and evaluated for their effectiveness as psychotherapists.

The third issue centers around remuneration. Despite their limited training in psychotherapy, family physicians can provide insured psychotherapeutic services for patients through the OHIP, while many trained psychotherapists are not covered. In the past there have been very limited insured psychotherapies in Ontario. However, with newer models of care like the Family Health Teams, professional psychotherapists can be part of the team and as such, can be available to provide patients with psychotherapeutic services.(22) This, however, has large funding implications; the Ontario government has to provide extra funding to cover psychotherapist fees within the Family Health Teams which increase health care spending. Even though the long term benefits of having a strong primary care have clearly been established in the literature(4), there is currently a moratorium on implementing new Family Health Teams in Ontario in an effort to curtail health care spending. Hence, there are many family physicians who do not practice within Family Health Teams and do not have access to trained psychotherapists. They

still have to provide mental health care to their patients themselves or refer to hospital clinics, other agencies or private services. For a patient who does not have the financial means to afford psychotherapy in the community, his or her family physician may be the only person to provide them with care.

5.2.3 A strong case for the provision of psychotherapy in primary collaborative mental health care in Ontario

There is a substantial body of literature in support of primary collaborative mental health care or primary shared mental care.(23)(8)(24) From the family physicians' perspective, Family Health Teams are a sensible way to strengthen primary care and foster collaborative care, not just in mental health but from the perspective of working with dietitians, pharmacists, occupation therapists etc. In the first study, most of the family physicians who were practicing in shared care models or Family Health Teams were happier and felt that their patients received better mental health care, specifically psychotherapy. Having psychiatric support increased family physicians' confidence in managing patients with mental illness. The presence of these insured services provide Ontarians better access to psychotherapeutic services.(22) In the policy study as well, we see that most policy documents support and recommend collaborative mental health care at the grass roots levels. Currently, psychotherapeutic services are available in Ontario through public agencies, organizations and hospital out-patient clinics. However, care often happens in silos, is disjointed and delayed.(25)(26) Collaborative mental health care provides care for patients by the mental health professional that is most appropriate to provide the care patients need. Collaboration brings together multiple mental health professionals and aligns them towards a common goal, the health of their patient. The

cost effectiveness of collaborative care is proven by data emerging from cost benefit analyses of similar collaborative mental health initiatives implemented by UK, Australia and other Scandinavian countries.(8)(27)

In Ontario, there can be a several ways to provide timely, efficient and collaborative mental health care in the community. One option could be to strengthen the organizations, agencies, institutions and programs providing mental health care in the community and foster collaboration and knowledge translation between them and physicians, (both family physicians and psychiatrists). A second option would be to enhance and strengthen Family Health Teams to provide basic primary health care and foster collaboration between these teams and other agencies. The emphasis would then be on provision of specialized mental health and therapeutics services through these community mental health programs and clinics.(6) However, only 40% Ontarians have access to a Family Health Team; hence, there is already a two tiered system in Ontario when it comes to accessing insured therapies through Family Health Teams. There needs to be more advocacy to ensure that all Ontarians have access to timely and appropriate insured mental health services.

5.2.4 Future direction in primary mental health care in Ontario

In the qualitative study family physicians expressed concerns and frustration at the lack of community resources for their patients, including psychiatric support and affordable psychotherapies. These shortcomings in the health care system are also visible in the mental health and addictions policy documents. Both the national and Ontario mental health strategies mention these service gaps and provide values and goals for their improvement. However, these strategies fail to provide concrete steps in implementing

solutions. Inadequate mental health care is a global phenomenon.(4) Many jurisdictions have implemented strategies and programs to meet the mental health care needs of their populations. The UK, Australia and Sweden, are some countries that have implemented publicly funded programs to provide community based collaborative mental health care and psychotherapy services with success.(8)(27) They accomplished this a decade ago. Why have Canada and Ontario lagged behind in implementing their mental health strategies, despite having the knowledge, the expertise and the will to do so?

The mental health policies of both Ontario and Canada are robust and based on solid principles as elaborated in chapter 4. There needs to be a clear strategy to oversee the implementation of this endeavor. There needs to be clarity on where sustainable funding will come from. In Ontario, Family Health Teams could be expanded to ensure that equitable services are available to everyone. There needs to be a clear process for ongoing evaluation and improvement. Academia has a responsibility to ensure competence in the workforce and to engage in collaborative research in primary mental health to inform future modification and refinement in services. There needs to be more collaboration with other social services, public agencies and the private sector to ensure that people with mental illness are supported across the spectrum of public services and to reduce redundancy.

5.3 Study limitations

Several limitations to this thesis should be noted. This is a qualitative study and the findings may not be transferable. The first study was limited to family physicians in Southwestern Ontario and did not reflect Ontario's diverse family physician population; hence, some issues or themes that are specific to some populations may have been

missed. The sample included more female participants that may have impacted the findings. Despite the limitations of this study, it provides a greater awareness into the perspectives and experiences of psychotherapy by family physicians, which is intended to enhance the present literature and encourage further research on the topic. With respect to the qualitative policy analysis, the findings would have been more robust and rich if the opinions and perspectives of various actors, (patients, families, psychiatrists, family physicians, counselors, educators), with interest and a stake in the mental health policy had been included. The current state of mental health care was extracted from documents and hence, reflects the government's and other institutions' positions on mental health and mental health services, which might be slightly different from the actual state of primary mental health care. This study predominantly used documents from Ontario, however, a comparative study of the mental health policy in other jurisdictions would have provided comparative data with respect to context, content and process. In spite of these limitations, the author concludes that these studies have provided useful insights into the domain of psychotherapy in family medicine and how critical qualitative policy document analysis is important to understand the dynamics of mental health policy.

It is evident from the discussion above that there are still many domains that require more research in the realm of mental health care. The role of family physicians in collaborative primary mental health care, the scope of practice and effectiveness of psychotherapy by family physicians (especially as it pertains to the new CRPO) and health policy research in primary mental health care are some such areas.

5.4 Conclusion

Taken together, the findings of the studies confirm that psychotherapy has not been given due attention in mental health care, despite the knowledge that it is an effective treatment modality in mental illness. Family physicians are practicing psychotherapy and therapeutic alliance and the patient-physician relationship likely play a role in their practice of psychotherapy. Family physicians are not adequately trained to conduct psychotherapy and would benefit from more formal teaching in this area. Patients benefit from having trained psychotherapists provide services in a team based setting.(27)

Collaboration with psychiatrists and other trained psychotherapists that is allied health professionals, is a key facilitator for family physicians' management of mental illness.

Implementing Family Health Teams in Ontario, where patients have access to insured psychotherapeutic services and timely psychiatric care could be one move in the right direction. However, only 40% Ontarians have access to Family Health Teams.(22)

Ontario's health policy supports managing mental illness in primary care, promotes collaborative care and envisions equitable, accessible, evidence based mental health care for patients with mental illness. However, the policy does not provide an adequate platform for the implementation of these goals. An implementation and evaluative strategy is needed. There are many positive steps being taken in Ontario, such as the presentation of a robust mental health and addictions strategy and implementation of Family Health Teams, but they need to be implemented and available across the province. The enormity and effects of mental illness cannot be ignored.

“There is no health without mental health.”

Changing Directions, Changing Lives (MHCC) 2012 (28)(p.61)

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Appendices

Appendix 1 Definitions of Psychotherapy³

Wikipedia the free encyclopedia

Psychotherapy is a set of techniques believed to cure or to help solve behavioral and other psychological problems in humans. The common part of these techniques is direct personal contact between therapist and patient mainly in the form of talking. Due to the nature of these communications, there are significant issues of patient privacy and/or client confidentiality.

World Health Organization

Psychotherapy refers to planned and structural interventions aimed at influencing behavior, mood and emotional patterns of reaction to different stimuli through verbal and non-verbal psychological means. Psychotherapy does not comprise the use of any biochemical or biological means

Canadian Psychiatric Association

Psychotherapy is a selected form of psychiatric treatment which employs specialized communication techniques practiced by a properly trained physician for the purpose of curing or reducing the psychiatric disability of the patient. In psychiatric practice , psychotherapy is usually carried out at intervals for a definite time duration, most often an hour or a fraction thereof.

Canadian Mental health association

Psychologists, Psychiatrists and some social workers practice psychotherapy. Getting treatment by psychotherapy means talking with a trained person who helps you solve problems by developing more positive thoughts and feelings. There are many different theories and schools of thought regarding effective psychotherapy techniques.

- a) Group therapy-several people talk about their problems and receive help from each other's remarks. A trained therapist leads the group
- b) Individual psychotherapy-the individual talks about problems without going deeply into the subconscious mind. (Note: The "subconscious" is that part of the mind which is not fully conscious, yet is able to influence our actions)

³ OACCPP. Consultation Discussion Guide On Issues Relating to the Ministerial Referral on Psychotherapy and Psychotherapist [Internet]. Ontario; Available from: http://www.oaccpp.ca/assets/Psychotherapy_Consultation_Discussion_Guide.pdf

c) Psychoanalysis-Therapists seek to uncover causes of emotional health problems by searching into a person's early experiences. Dream analysis and free association (talk about anything that comes to mind) are used to get to the subconscious mind).

United Kingdom Council for Psychotherapy (UKCP)

Psychotherapy is the provision by qualified practitioners of a formal and professional relationship within which patients/clients can profitably explore difficult and often painful emotions and experiences. These may include feelings of anxiety, depression, trauma, or perhaps the loss of meaning of one's life. It is a process which seeks to help the person gain an increased capacity for choice through which the individual becomes more autonomous and self-determined. Psychotherapy may be provided for individual or children, couples, families and groups.

Psychotherapy and counseling federation of Australia

While counseling and psychotherapy overlap considerably, there are some distinctive differences. The focus of counseling is more likely to be on specific problems or changes in life adjustment. Psychotherapists are more likely to work intensively with deeper issues and/or more deeply disturbed clients who are seen more frequently and over a longer period of time.

It is recognized that a wide range of professions may use a variety of counseling skills as part of their practice and that the term counseling is part of everyday language with different meaning indifferent psychotherapy as a profession. Compared with most other health professions counseling and psychotherapy are in a relatively early stage of development as a profession providing us with both opportunities and challenges in self-definition.

New Zealand Standard Classification of Occupations, Statistics New Zealand.

Description: Treats emotional distress and/or psychological disturbance occurring within and between individuals, families and groups.

Tasks: Undertakes initial assessment to establish a provisional diagnosis and formulation regarding the course of Psychotherapy, taking into account identified changes required in cognition, affect and functioning and the extent to which unconscious process related to present difficulties. Maintains their therapeutic relationship as a basis for discovering and exploring previously subconscious material and assist the process of integrating this experience into consciousness. Reviews assessment, formulation and progress of psychotherapy and the process of change. Maintains clinical supervision and attends to personal and professional education and development as a continuing process throughout working career.

Ordres des Psychologues du Quebec (Quebec Regulatory body for psychologists)

Psychotherapy is a structured interactional process that, based on a diagnosis, aims to treat a mental disorder by using psychological methods recognized by the scientific

community. It is a personal process in which the psychologist helps you to see more clearly, to explore and to take actions that lead to change.

American Psychotherapy Association

Psychotherapy is a “talking cure” in which unconscious thoughts, feelings and motives are brought into awareness. The objective is to integrate this conscious and unconscious material into a plan to reduce suffering and bring about constructive change.

Appendix 2 Definitions of Counseling⁴

Canadian counselors and Psychotherapist Association

Counseling is a relational process based upon the ethical use of specific professional competencies to facilitate human change. Counseling addresses wellness, relationships, personal growth, career development, mental health, and psychological illness or distress. The counseling process is characterized by the application of recognized cognitive, affective, expressive, somatic, spiritual, developmental, behavioral, learning, and systemic principles.(32)

The British Association for Counseling (BAC),

The BACP, may have been the first professional association to adopt a definition of professional counseling. In 1986 it published the following definition:

Counseling is the skilled and principled use of relationship to facilitate self- knowledge, emotional acceptance and growth and the optimal development of personal resources. The overall aim is to provide an opportunity to work towards living more satisfyingly and resourcefully. Counseling relationships will vary according to need but may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crisis, developing personal insights and knowledge, working through feelings of inner conflict or improving relationships with others. (33)

American Counseling Association(ACA)

Counseling is the application of mental health, psychological or human development principles, through cognitive, affective, behavioral or systemic interventions, strategies that address wellness, personal growth, or career development, as well as pathology

The definition also includes these additional attributes:

- a) Counseling deals with wellness, personal growth, career, and pathological concerns. In other words, counselors work in areas that involve relationships (Casey, 1996). These areas include intra- and interpersonal concerns related to finding meaning and adjustment in such settings as schools, families, and careers.
- b) Counseling is conducted with persons who are considered to be functioning well and those who are having more serious problems. Counseling meets the needs of a wide spectrum of people. Clients seen by counselors have developmental or situational concerns that require help in regard to adjustment or remediation. Their problems often require short-term intervention, but occasionally treatment may be extended to

⁴ OACCPP. Consultation Discussion Guide On Issues Relating to the Ministerial Referral on Psychotherapy and Psychotherapist [Internet]. Ontario; Available from: http://www.oacpp.ca/assets/Psychotherapy_Consultation_Discussion_Guide.pdf

encompass disorders included in the Diagnostic and Statistical Manual of Mental Disorders (1994) of the American Psychiatric Association.

c) Counseling is theory based. Counselors draw from a number of theoretical approaches, including those that are cognitive, affective, behavioral, and systemic. These theories may be applied to individuals, groups, and families.

d) Counseling is a process that maybe developmental or intervening. Counselors focus on their clients' goals. Thus, counseling involves both choice and change. In some cases, "counseling is a rehearsal for action"

Appendix 3 Criteria for training ⁵

Categories of registration and eligibility criteria for psychotherapy

Psychotherapy And Counseling Federation of Australia PACFA	National Board for Certified Counselors (USA)	United Kingdom Council for Psychotherapy (UKCP)	Irish Association for Counseling Therapy	Canadian Counseling Association	British Association for Counseling and Psychotherapy	New Zealand Association of Counselors
<p>Pathway 1 3 years' Training in Psychotherapy or Counseling (3 years - 400 hours min) 750 hours' client contact 75 hours' post-training supervision (minimum) over two years (minimum)</p> <p>Pathway 2 Relevant Degree (as defined by the Applicant's Professional Association) + Specialist Training in Psychotherapy or Counseling (2 years - 250 hours min) + 750 hours' client contact with 75 hours' post-training supervision (minimum) over two years (minimum)</p> <p>Pathway 3 A specialist training in Psychotherapy or Counseling (2 years - 250 hours minimum) +150 hours'</p>	<p>Option A Satisfactory performance on the National Counselor Examination is one of the criteria used by NBCC to identify professionals who may be eligible to become a National Certified Counselor.</p> <p>Option B Graduates of counseling programs approved by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP).</p> <p>Option C A practicing counselor with two or more years of experience and counseling supervision after the date your advanced degree (master's or higher) with a major study in counseling was conferred?</p> <p>Must answer yes for the following</p>	<p>As the UKCP is a peak organization, entry and curriculum requirements refer to members of member organizations.</p> <p>Entry Requirements</p> <p>1.1 Entry is at a postgraduate level of competence.</p> <p>1.2 Candidates must have personal qualities that make them suitable for the profession of psychotherapy</p> <p>1.3 Candidates should have relevant experience of working with people in a responsible role.</p> <p>The length of training shall be appropriate to permit the consolidation and integration of theoretical knowledge and clinical experience and shall not normally be shorter than four years.</p>	<p>An applicant must:</p> <ul style="list-style-type: none"> * Have completed a one year full-time or two/three years part time counseling course which provides: <p>Have completed a Core Counseling Course, which is a minimum of at least two years full or part time duration, which satisfies the criteria for course recognition by IACT including the following:</p> <ul style="list-style-type: none"> * A minimum of 100 hours of supervised individual client work during core course (where training commenced prior to September 1995, only 50 hours client work is required) * A minimum of 350 course hours including skills, theory and selfdevelopment 	<p>Category A: Full Member Individuals with a masters degree in counseling or related field from an institution recognized by AUCC</p> <p>Must show evidence of GRADUATE course work in:</p> <ul style="list-style-type: none"> * Counseling Theory (compulsory) * Supervised Practicum with at least 120 hours of direct client contact (compulsory) And GRADUATE course work in six (6) of the following: * Communication and Relationship Skills * Group Counseling * Theory of Career Development * Assessment and Testing * Research and Evaluation * Consultation Methods 	<p>Routes to Accreditation</p> <p>1) Individual has completed a BACP Accredited Counselor Training Course and has 450 hours of supervised counseling practice over at least 3 years and not more than 5 years.</p> <p>2) Individual has undertaken 450 hours of counseling training comprising of two elements</p> <p>a) 200 hours of skills development</p> <p>b) 250 hours of theory and has 450 hours of supervised counseling practice over at least 3 years and no more than 5 years.</p> <p>3) Individual can provide evidence of</p> <p>a) some formal counseling training and</p> <p>b) several years of practice (of 150hours minimum per year, under</p>	<p>A) Through Approved Training</p> <p>A person who has:</p> <ul style="list-style-type: none"> * Completed cohesive and comprehensive counseling training through a program approved by the Association. * A record of bi-cultural learning and / or experience, including marae experience, has sensitivity to Treaty of Waitangi issues and can demonstrate an understanding of Tikanga Maori. * Completed a selfawareness and personal growth component including counselor as client and group therapeutic process. * Completed face to face practice as a counselor (400 hours). * Submitted a recent satisfactory report from a

⁵ OACCPP. Consultation Discussion Guide On Issues Relating to the Ministerial Referral on Psychotherapy and Psychotherapist [Internet]. Ontario; Available from: http://www.oaccpp.ca/assets/Psychotherapy_Consultation_Discussion_Guide.pdf

<p>additional professional training which was completed after the Specialist Training, and which was more advanced and/or more specialised than the Applicant's previous Specialist Training. Any course include here must have been successfully completed. These 150 additional hours must comprise: the first 150 hours of a larger course which is more advanced and/or more specialised than Applicant's previously completed Specialist Training. Or two courses of at least 75 hours each which are more advanced and/or more specialised than the Applicant's previously completed Specialist Training. Or a package of advanced and/or more specialised shorter courses (in total, 150 hours minimum) that includes a significant progression from one course to the next. Note: Conference</p>	<p>questions. (A) In your degree program, were more than half the courses you completed and at least 24 semester hours representative of a course in each of the following areas: * Human Growth and Development * Social/Cultural Foundations * Helping Relationships (Counseling Theories and Techniques) * Group Work * Career and Lifestyle Development * Appraisal (Tests and Measurements for Individuals and Groups) * Research and Program Evaluation * Professional Orientation (to counseling) * Field experiences in counseling for academic credit (B) 48 semester hours (or 72 quarter hours) of graduate coursework in counseling including a course in each of the above area(s) and two academic terms of field experience in counseling for graduate credit? (Coursework outside the</p>	<p>The Minimum Curriculum. 1.4 The study of the theory and practice of psychotherapy from assessment to termination. This should include: a model of the person and mind. a model of gendered and culturally influenced human development a model of human change and ways in which change can be facilitated. a set of clinical concepts to relate theory to practice. an extensive literature which includes a critique of the model. 1.5 Acquisition of a critical understanding of the relevance of studies and research findings in human development, psychopathology, sexuality, ethics and social science. 1.6 Supervised practice of psychotherapy. .7 Arrangements to ensure that the trainees can identify and manage appropriately their personal involvement in and contribution to the</p>	<p>t. A minimum of 450 course hours of staff-student contact, including skills, theory and self-development * A detailed study of at least one major school of counseling with an introduction to other schools/models of counseling for comparison and contrast * A minimum of 50 hours of personal therapy during training * Assessment of applicants for suitability before being selected onto course * Certification of having satisfactorily completed course After training, an applicant must: Have completed 450 hours of individual client work with evidence of one hour of supervision for every 10 hours of counseling, of which at least 75% must have been in one-to-one supervision. Supervision of these 450 hours of work must not be undertaken with a supervisor, who either supervised the applicant while</p>	<p>* Learning and Human Development * Psychological Education * Counseling Intervention Strategies * Gender Issues * Multicultural Counseling * Counseling in Specialized Settings * Professional Ethics</p>	<p>formal supervision). This includes a requirement for at least 450 hours of supervised counseling practice over at least 3 years. * 75 hours of completed counselor training = 1 unit * 1 year of supervised practice = 1 unit Together the total must add up to 10 units. Applicants claiming two or more training units must show a balance of theory and skills approximately in line with that states in route number 1). 4) Can provide evidence of: a) having obtained S/NVQ Level III in counseling (= 4 units) b) Four or five years of supervised practice (of 150 hours minimum per year under formal supervision. This includes a requirement for at least 450 hours of counseling practice supervised over 3 years. At least two year must be subsequent to obtaining the S/NVQ Level III qualification. Together the total must</p>	<p>supervisor acceptable to NZAC, who has been the candidate's supervisor for at least 6 months. * Had their suitability for Membership confirmed in an interview by a panel of Members on behalf of the Membership Committee. Notes An approved training program is of a minimum of one year full-time equivalence, and integrates relevant cultural and social awareness and sensitivity; theoretical knowledge; skills training; personal awareness; professional practice; and practice supervision components. Of the total 400 hours of counseling practice a minimum of 100 hours is to be completed and supervised during training and a minimum 200 hours post-training. Internship students who during their training programs complete more than 400 hours of face-to-face supervised counseling (not including</p>
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<p>attendances do not meet these criteria. + 1,200 hours' client contact + 120 hours' posttraining supervision over three years (minimum) Pathway 4 Recognition of Prior learning. Where an applicant's professional training and formation does not fit the above pathways, but is based on extensive training, practice and supervision over several years, it may be possible to be admitted to the Register based on recognition of this prior learning</p>	<p>degree program completed for graduate credit at a regionally accredited college or university is acceptable as long as the conditions in question 3a are met.) (C) 3,000 hours of work as a counselor over at least two years since the date your advanced degree with a major study in counseling was conferred. (D) 100 hours of face-to-face counseling supervision over a minimum of two years since the date of your advanced degree with a major study in counseling was conferred? Your counseling supervisor(s) must hold an advanced degree in counseling or a closely related field (social work, psychology, or marriage and family therapy) and must not be related to you by blood, marriage, dating, engagement, etc. Option D State credentialed for independent practice in counseling and can answer</p>	<p>processes of the psychotherapies that they practice. 1.8 An introduction to the range of psychotherapies and counseling so that trainees may have an awareness of alternative treatments. 1.9 An opportunity for trainees to develop the capacity to recognize severely disturbed clients. 1.10 The development of ability to recognize when the practitioner should seek other professional advice. 1.11 Understanding of basic research techniques and their application to the investigation and evaluation of psychotherapeutic interventions from assessment to termination of treatment. Qualification and Registration. 5.1 Training organizations shall specify whether qualification coincides with recognition of candidates as eligible for Registration by UKCP.</p>	<p>a student during training, or was involved as a core trainer or assessor on the core course Have been in ongoing supervision in Ireland with the same supervisor for one year immediately preceding application. Non Recognized Course Criteria: If the core course is not an IACT recognized course, it is essential to include with the application the course brochure giving the course details, which show that its criteria are equivalent to the IACT current criteria for course recognition. The details required of the applicant's core course include: * Name of the course and the training organization * Starting and ending date of course * Entry requirements for the course * Qualification of staff * Number of hours of theory and skills training * Number of contact hours on the course * Number of supervised</p>		<p>add up to 10 units. One year of supervised practice = 1 unit 75 hours of CPF = 1 unit In addition to the above, an applicant must meet the following criteria: * has agreed to formal arrangement for counseling supervision of a minimum of 1 ½ hours monthly during the accreditation period * Gives evidence of serious commitment to professional and personal development * Is a current member of BACP * Has a philosophy of counseling which integrates training, experience, further development and practice Evidence of one core theoretical model should be demonstrated. * Demonstrates practice which adheres to the BACP Ethical Framework. * 40 hours of personal counseling or an equivalent activity consistent with the applicant's core theoretical model.</p>	<p>counseling skills practice), confirmed by a statement from their trainers, may apply for consideration for membership on the recommendation of their trainers, without completing any further post training counseling hours. Any such application would be for the equivalent of 200 hours of post training practice e.g.; long standing practice in a particular counseling position or internship. The post training face-to-face counseling is to have been supervised for at least 20 (1 hour) sessions with a supervisor acceptable to NZAC. (B) Through Particular Circumstances A person who has: * Granted Membership based on that person's particular circumstances and presents with the qualities, knowledge, skills and experience of a</p>
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	<p>yes to each of the following questions: (A) Are you fully credentialed for independent general counseling practice by one of the state boards (B) Do you hold an advanced degree (master's or higher) in a mental health field from a regionally accredited college or university? Administration and education are not considered mental health fields. Option E An advanced degree (master's or higher) with a major study in counseling from a regionally accredited college or university but are unable to document at least 3,000 hours of work as a counselor and/or 100 hours of face-to-face counseling supervision over at least two years since the date your advanced degree with a major study in counseling was conferred? IF YES, answer the following</p>	<p>5.2 Where qualification and registration do not coincide, organizations are to specify what further professional development is required for registration. 5.3 The definition of such further professional development might include considerations relating to the nature of supervision and the range, quantity and intensity of practice and/or study. 5.4 Where qualification and Registration do not coincide, the process of assessment of readiness for Registration shall correspond in general to the requirements of Section 3 above. 6. Continued Professional Development. 6.1 Training organizations shall bear in mind a commitment to life long learning and the need for monitoring practice for the best protection of the public. 6.2 Each training organization should make</p>	<p>client hours as part of the course * Assessment methods used by the course</p>		<p>* Serious commitment to working with issues of difference and equality in counseling practice.</p>	<p>candidate who qualifies under 1. * A record of bi-cultural learning and/or experience, including marae experience, has sensitivity to Treaty of Waitangi issues and can demonstrate an understanding of Tikanga Maori. * Completed a selfawareness and personal growth component including counselor as client and group therapeutic process. * A record of satisfactory face-to-face practice as a counselor. * Submitted a recent satisfactory report from a supervisor acceptable to NZAC who has been the candidate's supervisor for at least 6 months. * Had their suitability for Membership confirmed in an interview by a panel of Members on behalf of the Membership Committee. Notes This option is a vehicle for recognising personal development, learning and experience from a variety of sources, including extensive</p>
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	<p>questions: (A) In your degree program, were more than half the courses you completed and at least 24 semester hours clearly representative of a course in each of the following areas: * Human Growth and Development * Social/Cultural Foundations * Helping Relationships (Counseling Theories and Techniques) * Group Work * Career and Lifestyle Development * Appraisal (Tests and Measurements for Individuals and Groups) * Research and Program Evaluation * Professional Orientation (to counseling) * Field experiences in counseling for academic credit (B) Did you complete at least 48 semester (or 72 quarter hours) of graduate coursework in counseling including a course in each of the above areas and two academic terms of field experience in counseling? (Coursework outside the degree program</p>	<p>provision for an ongoing graduate body either as an integral part of the organization or clearly linked to it. 6.3 Training organizations should encourage their graduates actively to consider their continuing professional development needs. 6.4 Training Organisations must make provision for the continued professional development of their graduates.</p>				<p>supervised counseling practice, which the candidate has been able to integrate to form their own professional foundation for counseling work. The onus is on the candidate to demonstrate that they have acquired in other ways the awareness, theoretical knowledge, skills and experience normally found in an approved training program, achieved appropriate levels of competency and integrated different sources of learning. Detailed information and evidence must be provided. Through Special Invitation A person who is: * Invited to become a Member by resolution of the National Executive.</p>
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	<p>completed for graduate credit at a regionally accredited college or university is acceptable as long as certain conditions).</p>					
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<p>Psychology Canada guide to become a psychologist in Ontario and become a member of The College of Psychologists of Ontario CPO</p>	<p>Canadian Association for Social work Education CASWE Curricular requirements to become a member of the Ontario College of Social Workers and Social Service workers OCSWSSW</p>
<p>How to Become a Psychologist in Ontario</p> <p>Last Updated: March 18th, 2011 by Psychology Canada & filed under featured, How to Become a Psychologist, Ontario.</p> <p>First: Obtain An Undergraduate Degree To become a Psychologist in Ontario there are four different certificates to register under the The College of Psychologists of Ontario. These include a Psychologist with Supervised Practice, Psychological Associate with Supervised Practice, Psychologist Interim Autonomous Practice, and Psychological Associate Interim Autonomous Practice. Overall the minimum requirements is to have a Masters Degree in Psychology with at least four years of post-masters degree experience to register as a Psychological Associate with Supervised practice. So first things first; you need to earn an undergraduate degree in Psychology (or equivalent):</p> <p>Second: Obtain a Masters Degree or Higher In Ontario you must have at minimum a Masters Degree in Psychology supplemented by four years of related experience after obtaining a Masters Degree in order to register as an Ontario Psychological Associate with a Supervised Practice. The difference between a Psychological Associate and Psychologist in Ontario is as follows:</p> <p>Psychological Associate: Supervised Practice Applying for a certificate as a Psychological Associated with Supervised Practice required a Psychology Masters Degree, and you must not have previously registered for the practice of psychology anywhere. Or you have a Masters degree, and have been registered elsewhere where the requirements to register are not comparable to Ontario's registration requirements. Psychologist: Supervised Practice</p> <p>Applying for a certificate as a Psychologist with a Supervised Practice requires a Doctoral Degree in Psychology, and you must not have been previously registered as a Psychologist anywhere else. Or you have a Doctoral Degree in Psychology and have been registered as a Psychologist for less than five years elsewhere where the requirements are not comparable to Ontario's registration requirements. Psychological Associate: Interim Autonomous Practice</p> <p>To register as a Psychological Associate Interim Autonomous Practice certificate you must have been registered on the basis of a Masters Degree for the independent practice of Psychology in a place other than Ontario continuously for five years preceding registration.</p> <p>Psychologist: Interim Autonomous Practice To register as a Psychologist Interim Autonomous Practice</p>	<p>The curriculum at the Baccalaureate level (BSW curriculum) provides students with knowledge and skills for generalist practice, while the curriculum at the Master level (MSW curriculum) provides knowledge and skills in research/scholarship, professional leadership, social work supervision and advanced practice and/or areas of specialization. Schools use the core learning objectives for students as points of reference for both BSW and MSW programs. Learning objectives for students applicable only to MSW programs are specified to reflect an advanced level of knowledge and skills in selected major areas of social work practice as mentioned above.</p> <p>The Core Learning Objectives for Students are as follows:</p> <ol style="list-style-type: none"> 1. Identify as a professional social worker and adopt a value perspective of the social work profession 2. Adhere to social work values and ethics in professional practice 3. Promote human rights and social justice 4. Support and enhance diversity by addressing structural sources of inequity 5. Employ critical thinking in professional practice 6. Engage in research 7. Participate in policy analysis and development 8. Engage in organizational and societal systems' change through professional practice towards changing oppressive social conditions. 9. Engage with individuals, families, groups, and communities through professional <p>BSW Curriculum SB 3.1.1 The BSW curriculum equips students with knowledge in the humanities and relevant social sciences, including knowledge related to human development and human behavior in the social environment. SB 3.1.2 The four-year BSW curriculum reflects a balance of general education (at least 40 percent) and professional education (at least 50 percent) and a field practicum of at least 700 hours. The Quebec three-year programs essentially cover professional social work education and the field practicum, while liberal arts are principally covered at the CEGEP level. SB 3.1.3 The curriculum for a second undergraduate degree program provides professional social work content equivalent to that in a four-year BSW.</p>

<p>certificate you must have been registered on the basis of a Doctoral Degree for the independent practice of Psychology in a place other than Ontario continuously for five years preceding registration.</p> <p>Third: Where and How do I Register? Where to register as a Psychological Associate or Psychologist in Ontario: The College of Psychologists of Ontario. There is a page at the College's website for prospective members to help determine which certificate for which you may be eligible to apply for (Psychological Associate, Psychologist etc.). You can find that page HERE. It is a pretty simple algorithmic like questionnaire, but can be used as a simple introduction if you are unaware of the requirements to register as a Psychological Associate or Psychologist in Ontario.</p> <p>You can apply as a Candidate standing if you are currently completing your Masters degree for a Psychological Associate Candidates, or as a Psychologist Candidate if you are currently accepted into a Doctoral program. This is with the expectation that you are working towards completing your requirements.</p> <p>Below I will give you a quick skim of what it takes to register in the various registered certificates. If you would like further information on the official registration information as outlined by the The College of Psychologists of Ontario then please visit the Prospective Members page and scroll down to the bottom where you can find out how to register under the following certificates:</p> <p>Psychological Associate: Supervised Practice</p> <p>The College of Psychologists of Ontario describes the Psychological Associate with Supervised Practice as a "temporary and transitional period during which the candidate actively prepared for autonomous practice". The practice should be at least a year, and not more than two years. This is to further asses any danger against the public.</p> <p>The ultimate goal is to be able to practice autonomously which will in the end require all of the following: Submission of application, three references, and transcripts Masters Degree in Psychology from an acceptable institution At least four years of relatable experience post Masters Degree. Completed your period of 'supervised practice'. Pass the Examination for Professional Practice in Psychology (EPPP) Pass the College's Jurisprudence and Ethics Examination Pass the College's Oral Examination Completed any further training that may be required by the College. Psychologist: Supervised Practice</p> <p>The certificate application requirements for the Psychologist with a Supervised Practice is very similar with a few exceptions, of which the largest is the possession of a Doctoral Degree in Psychology. And the required supervised practice hours must be a minimum of 3000 hours with at least 1500 hours (1 year) being post Doctoral.</p> <p>Below are all the requirements you should fulfil for the autonomous practice as a Psychologist in Ontario:</p> <p>Submission of application, three references, and transcripts Doctoral Degree in Psychology from an acceptable institution Completed your period of 'supervised practice'. Pass the Examination for Professional Practice in Psychology</p>	<p>SB 3.1.4 The foundation component of the MSW curriculum is equivalent to the content of the BSW curriculum. MSW Curriculum SM 3.1.1 The academic unit specifies the particular areas of specialization and/or advanced study which characterize the program within the context of the academic unit's mission. The MSW curriculum includes theories, policies and practices relevant to the student's selected major area of social work practice (i.e., research/scholarship, professional leadership, social work supervision and advanced practice and/or areas of specialization). SM 3.1.2 Students with a first level accredited social work degree may be admitted to a one-year graduate social work program. Students without a first level social work degree may be admitted to a two year graduate social work program. SM 3.1.3 Programs for students admitted with a first level social work degree include a specialized or advanced study component of at least 18 credit hours of course work, a practicum of at least 450 hours and/or a thesis or memoire, as defined by the program's university, such as to provide an opportunity for the integration and demonstration of advanced social work skills in practice, and/or policy analysis and/or research. SM 3.1.4 Programs for students admitted without a first level social work degree include two components: C A S W E - A C F T S A c c r e d i t a t i o n S t a n d a r d s - M a y 2 0 1 2 Page 15 of 20 i) A foundation component of at least 8 one-semester courses or equivalent, and a field practicum of at least 450 hours such as to achieve a level of preparation sufficient to equip the student to engage in MSW studies at a level equivalent to their counterparts with the BSW; and ii) An advanced study component of at least 6 one-semester courses or equivalent, a practicum of at least 450 hours and/or a thesis or memoire, as defined by the program's university, such as to provide for the integration and demonstration of advanced social work skills in practice and/or policy analysis and/or research. BSW/MSW Curriculum SB/M 3.1.5 Credit transfer is a mechanism of the recognition of degrees and accumulation of credits to accommodate for student and worker mobility across Canada and internationally. Social work academic units set up clear and transparent policies with regard to transfer credit between schools, college programs, schools of social work, nationally and internationally, within the context of general university regulations.</p> <p>3.2 Field Education Preamble</p>
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<p>(EPPP) Pass the College's Jurisprudence and Ethics Examination Pass the College's Oral Examination Completed any further training that may be required by the College. Psychological Associate: Interim Autonomous Practice</p> <p>To register with a Psychological Associate Interim Autonomous Practice certificate there are essentially two guidelines you must follow:</p> <p>You have practiced Psychology continuously for five years just previous to applying for the certificate, and this must have been in a jurisdiction that the college has an written agreement with, or the requirements of both are very similar to the College's. Be registered in a Canadian jurisdiction registered with the Canadian Register of Health Service Providers in Psychology (CRHSPP) or the National Register of Health Service Providers in Psychology. Psychologist: Interim Autonomous Practice</p> <p>Registering as a Psychologist Interim Autonomous Practice is very similar and follows these three generic steps:</p> <p>You have practiced Psychology continuously for five years just previous to applying for the certificate, and this must have been in a jurisdiction that the college has an written agreement with, or the requirements of both are very similar to the College's. Have the current Certificate of Professional Qualification (CPQ) awarded by the Association of State and Provincial Psychology Boards (ASPPB) OR Be registered in a Canadian jurisdiction registered with the Canadian Register of Health Service Providers in Psychology (CRHSPP) or the National Register of Health Service Providers in Psychology. For more information on registering as a Psychological Associate or Psychologist in Ontario please visit the The College of Psychologists of Ontario website.</p>	<p>Field education is considered a central component of social work education because the integration of knowledge, values and skills in the context of field education is a critical and distinctive aspect of social work education. The purpose of field education is to connect the theoretical/conceptual contributions of the academic setting with the practice setting, enabling the student to acquire practice skills that reflect the learning objectives for students identified in the Standards. Each program may vary its delivery of the field education component according to the nature and objectives of program and the influences of its university and local context.</p> <p>Standards Field Education Curriculum SB/M 3.2.1 The curriculum is consistent with the program's mission and goals and reflects the values of the relevant Social Work Codes of Ethics. SB 3.2.2 BSW programs provide students with a minimum of 700 practice hours. Where academic credit is given for previous work and/or relevant experience in lieu of the practicum, the academic unit has written policy that specifies clear criteria and procedures used to assess skills and knowledge normally obtained through the practicum. Academic credit for previous work and/or relevant experience may be provided for a maximum of one half of the required hours of practicum specified in the program (e.g., 350 hours of 700 required hours). SM 3.2.2 A one-year MSW program provides a minimum of 450 practicum hours and/or a thesis or memoire. A two year MSW program provides a minimum of 450 C A S W E - A C F T S A c c r e d i t a t i o n S t a n d a r d s – M a y 2 0 1 2 Page 16 of 20 practicum hours plus an additional 450 practicum hours and /or a thesis or memoire. SM 3.2.3 All students enrolled at the second university level who do not have a first level social work degree must complete a minimum of one practicum of at least 450 hours during their program. SB/M 3.2.4 The field education curriculum provides opportunities for students to acquire, apply, and demonstrate knowledge and skills congruent with social work values and with the core learning objectives for students as defined in this document (Preamble 3.1). i) The program provides activities for the integration of field and classroom education. ii) While simulations and labs may form an acceptable part of direct practice teaching, they are not substitutes for direct responsibilities in real practice situations. iii) The academic unit has a written policy on field placements within a student's workplace. In the case of field placements in the student's workplace, there is an educational focus with a clear</p>
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	<p>differentiation between work duties and student learning assignments. iv) Appropriate resources are made available to the field education component of the program to ensure that the educational purpose is achieved.</p>
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Appendix 4 CPSO Controlled Acts⁶

Controlled Acts that physicians can perform as per the College of Physicians and Surgeons of Ontario CPSO

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger, i. beyond the external ear canal, ii. beyond the point in the nasal passages where they are normally narrow, iii. beyond the larynx, iv. beyond the opening of the urethra, v. beyond the labia majora, vi. beyond the anal verge, or vii. into an artificial opening in the body.
7. Applying or ordering the application of a form of energy prescribed by their regulations under the RHPA.
8. Prescribing, dispensing, selling or compounding a drug as defined in the Drug and Pharmacies Regulation Act, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or device used inside the mouth to prevent the teeth from abnormal functioning.

⁶ The College of Physicians and Surgeons of Ontario [Internet] p. Legislation & By-Laws. Available from: <http://www.cpso.on.ca/policies/legislation/default.aspx?id=1768>

12. Managing labor or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behavior, communication or social functioning.

Appendix 5 Patient Centered Clinical Method⁷

8 PATIENT-CENTERED MEDICINE: TRANSFORMING THE CLINICAL METHOD

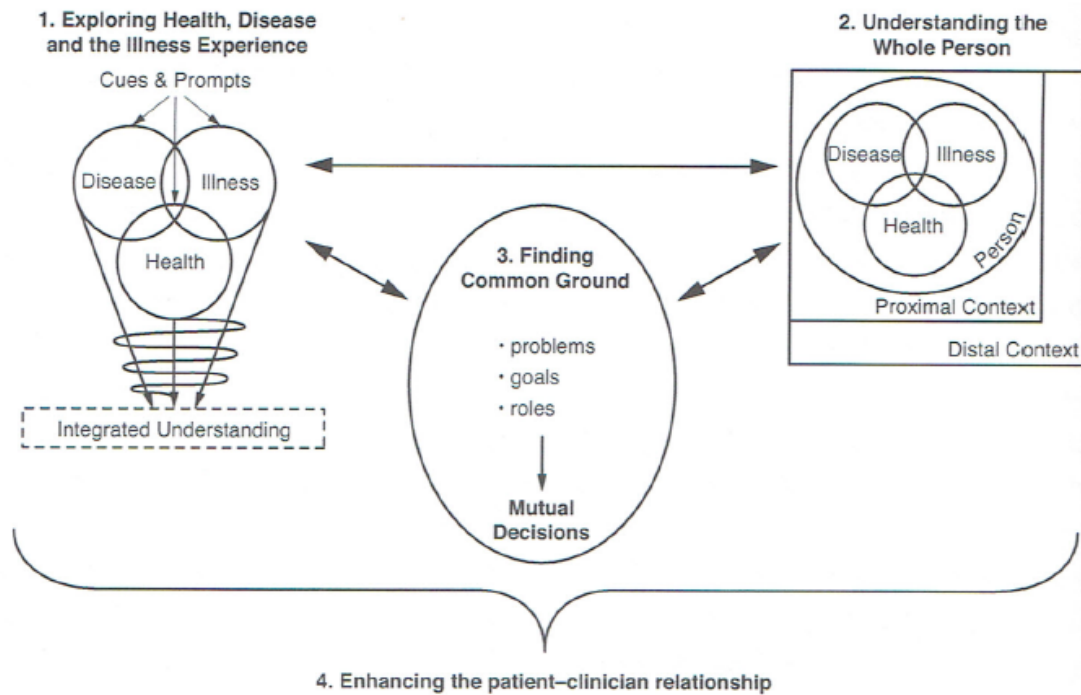


FIGURE 1.2 The patient-centered clinical method: four interactive components

⁷ Patient-centered medicine: transforming the clinical method' 3rd edition. By Moira Stewart, Judith Belle Brown, W. Wayne Weston, Ian R. McWhinney, Carol L. McWilliam and Thomas R. Freeman. London: Radcliffe Publishing Ltd; 2014. ISBN 978 1 846 19566 2

Appendix 6 Letter of Information

Letter of Information for Participant: Psychotherapy in Family Medicine

Investigator:

My name is Saadia Hameed and I am a candidate for the Masters of Clinical Science (FM) in the Department of Family Medicine at the University of Western Ontario. This study is part of my Research Thesis for the Master's Degree. My supervisors for the Thesis are Drs. Laura Lewis and Evelyn Vingilis. Dr Laura Lewis is the PI (Principal Investigator) of this study and any questions or comments can be addressed to her at

Name: Dr Laura Lewis BSW, MSW, PhD (SW)

...

Introduction and Purpose of the Study:

You are invited to participate in an individual interview to explore your thoughts, ideas and experiences around the use of psychotherapy in Family Medicine and the factors that shape and influence it. The intent is to use descriptive qualitative methods to get an understanding of how Family Physicians in Ontario practice psychotherapy.

Who can Participate:

You are invited to participate in this research if you are a practicing family physician in Ontario. In order to be eligible to participate, you must be between the ages of 25 and 65 years.

What will the study involve:

The interview will take place at a location and time that is convenient to you and will take approximately 30 to 45 minutes. The interview will be audiotaped and transcribed verbatim. At the completion of analysis of the interviews you may be contacted to check if our understanding of your experience reflects what you told us.

Confidentiality and Privacy:

All information for this study is confidential. Each participant is assigned a three digit identification code number. All participant identifiers will remain in a master demographic list. This list (hard copy) will remain separate from the actual data and kept in a locked and safe place (in a locked filing cabinet at my home office). It will be destroyed when the thesis/study is completed. The voice file of the interview will be sent to a professional transcriptionist to be transcribed verbatim. The transcriber will sign a statement of confidentiality. If you use any names during the interview they will not be transcribed, but simply replaced with the word "name" or "place" (for example. John="name"). All audio files will be kept till the end of the study. All electronic files (transcripts) will be kept safe on a password protected and encrypted flash drive, while the hardcopies (forms and transcripts) will be stored securely in a locked filing cabinet, for a minimum of seven years. The advisory team (the three investigators mentioned

above) for this study will be meeting to see the data documents for analysis, at UWO from time to time.

Voluntary Participation:

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions. You can withdraw from the study at any time before the data is analysed and incorporated into the thesis.

Risks and Benefits:

We see no risks associated with this research. There could be some discomfort in answering questions regarding your practice of psychotherapy. The benefits include gaining a better understanding of the practice of psychotherapy in Family Medicine, and allowing you to make suggestions for change. Also talking about your practice could be a reflexive exercise about your practice, however, you may not benefit personally from your participation.

Do you Have Questions:

If the results of the study are published, your name will not be used and no information that discloses your identity will be released or published without your explicit consent to the disclosure.

If you have any questions about your rights as a research participant or the conduct of the study, please contact Dr. David Hill, Scientific Director, Lawson Research Institute at (519)667-6649. Representatives of the University of Western Ontario Health Sciences Research Ethics Board may require access to your study-related records or may follow up with you to monitor the conduct of the research.

If you have any questions regarding your participation in this study please contact me, at ...

Thank you for your consideration.

Saadia Hameed MBBS CFPC

Appendix 7 Interview Guide

Semi Structured Interview Guide: Psychotherapy in Family Medicine

1. Demographics

- Age
- Gender
- How long in practice
- Type of practice (urban, rural, inner city, any special focus sub population)
- Compensation model (solo, FHG,FHO, FHT, Academic etc)

2. Definition of psychotherapy

- How do you define psychotherapy? (probe: counselling vs. psychotherapy)

3. Scope of practice

- What kinds of mental health issues do you see in your practice? (Probe: medical diagnoses vs life stresses. Role of continuity of care in psychotherapy)
- Can you tell me about the kinds of psychotherapy services you offer to your patients? (why skills vs guidelines)
- How often do you see your psychotherapy patients? (Probe How long are your sessions? What are some of the factors that influence how often you see them?)
- How long are your appointment times?
- How does prescription medication fit in with your practice of psychotherapy (Probe: how often do you pair psychotherapy with medication)
- What are some of the factors that affect your practice of psychotherapy?

4. Gender

- Do you feel your gender influences your practice of psychotherapy?

5. Training

- Can you describe what kind of training you received to do psychotherapy?
- Did it prepare you to assume the practice of psychotherapy?
- What has contributed the most to your skill in working with mental health issues? (Depth-why/how?)
- What do you wish had been a part of your training for practicing psychotherapy?

6. Satisfaction

- How does practicing psychotherapy affect you? (Probe: depth-why, Satisfaction vs. dissatisfaction)
- Does the method of compensation affect your practice of psychotherapy? (Probe Billing codes)
- Do you have any concerns about the practice of psychotherapy within your discipline?
- What will help you to keep on providing psychotherapy to your patients?

CODE # _____

Name _____

6 Demographics

Age _____

Gender Male ___ Female ___

How long in practice _____ years

Type of practice

Urban ___

Rural ___

Inner city ___

Sub populations ___

Compensation model

Solo ___

FHG ___

FHO ___

FHT ___

Academic ___

Other ___

Appendix 8 Ethics Approval



Office of Research Ethics

The University of Western Ontario
 Room 4180 Support Services Building, London, ON, Canada N6A 5C1
 Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
 Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. L. Lewis

Review Number: 16574E

Review Level: Expedited

Review Date: November 09, 2009

Protocol Title: Psychotherapy in Family Medicine

Department and Institution: Social Work, University of Western Ontario

Sponsor:

Ethics Approval Date: November 17, 2009

Expiry Date: April 30, 2011

Documents Reviewed and Approved: UWO Protocol, Letter of Information and Consent

Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

- a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
- b) all adverse and unexpected experiences or events that are both serious and unexpected;
- c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Joseph Gilbert

Appendix 9 Data Extraction Guide

1-What is the reasoning, if any, given for the presence/absence of policy elements?

Policy Elements:

a-Definition of psychotherapy/counseling

b-Reference to psychotherapy /counseling in treatment of mental illness (this can be regarding actual therapy or about the human resources needed for therapy-broad based)

c-Framework, conditions or importance of treating mental illness (especially in context of patient/family/community)

d-Implementation or delivery of mental health services

e-Any reference to justice, equity, entitlements, rights, responsibilities, citizenship, public participation and Canada Health Act

2-What conception of justice is present explicitly or implicitly?

3-What values are operating?

4-What assumptions are operating regarding delivery of psychotherapy/counseling in mental health care?

Definitions

Assumptions: The moral dimension in policy may not be readily visible but can be made visible through the analysis of underlying assumptions and values. Unpacking terms loaded with values and questionable assumptions does that.

Values: are views about what is important and in the political and policy arenas they are beliefs about the ends of goals of social institutions and structures. Values operate at the level of individuals, of institutions and or entire societies. Values can compete with each other.

Curriculum Vitae

SAADIA NASREEN HAMEED MBBS CFPC

EDUCATION

- 2007-2015 **Master of Clinical Science (Candidate)**
Graduate Studies, Department of Family Medicine, Western University
London, Ontario
- 2007-2008 **Postgraduate Fellowship in Academic Family Medicine**
Family Medicine Program, Western University
London, Ontario
- 2005-2007 **Post Graduate Residency in Family Medicine**
Urban Family Medicine Program, Western University
London, Ontario
- 2004-2005 **Undergraduate Medical Education**
3rd year clerkship as part of the International Medical Graduate Program
Ontario
- 1995-2001 **Medical Bachelor and Bachelor of Surgery (MBBS)**
University of Punjab
Pakistan

AWARDS AND HONOURS

Western University

- 2015 **Family Medicine Special Project Fund**, Citywide Department of Family
Medicine, London Ontario.
- 2012 **Martin J Bass Award**, Graduate Studies, Department of Family Medicine

University of Punjab

- 1995-2000 **Honours Standing years I, II, III, IV and V** Medical Bachelor and Bachelor
of Surgery program (MBBS)

Rawalpindi Education Board, Pakistan

- 1994 **Quaid e Azam Scholarship and Gold Medal**, for distinction in post-
secondary education

Teaching awards

- 2015 Awarded Best Core Preceptor in Family Medicine (London Urban)
- 2012 Nomination for PAIRO Award for Best Teacher
- 2010 Best teacher in undergraduate medical education (identified by students)

PROFESSIONAL EXPERIENCE

- 2014-present Medical Examiner for sexual assault
- 2008-present Clinical team leader, St. Joseph's Family Medical Centre
London, Ontario.
- 2006-2007 Chief Resident, St. Joseph's Family Medical Center,
London, Ontario
- 2001-2002 Anchorperson for current affairs programs, Pakistan Television
- 2001-2002 Anchorperson for current affairs programs, Pakistan Broadcasting
Corporation
- 2001-2002 House surgeon, Surgical Unit II, Holy Family Hospital
Rawalpindi Pakistan
- 2001-2002 House Officer, Pathology, Holy Family Hospital
Rawalpindi Pakistan

ACADEMIC APPOINTMENTS

- 2008-present Assistant Professor, Department of Family Medicine, Schulich School of
Medicine and Dentistry, Western University

TEACHING

- 2015 Lecture on cultural competence for IMG trainee physicians from the
middle east to Canada
- 2015 Revamping the mandatory Behavioural Science curriculum for
postgraduate trainees in Family Medicine
- 2015 Curriculum development and facilitation of 1 week online case based
module on back pain for 4th year Undergraduate Medicine
- 2012-2013 Clinical Teaching and Practice Experience course supervisor. Master of
Clinical Science (MCISc)
- 2010-2013 Lecturer/workshop presenter, Approach to chronic opioid prescribing for
Family Medicine postgraduate trainees
- 2010-present Co-facilitator and Lecturer, PGY1 and 2 Academic Half Day Sessions on
PCCM
- 2010-present CME facilitator for Problem Based Small Group Learning for 10 Family
Physicians in London Ontario (McMaster Modules)
- 2009-present Hand on trainer and superuser, EMR training for post graduate Family
Medicine trainees
- 2008-present Clinical team leader and core preceptor for post graduate medical trainees
in Family Medicine
- 2008-present Clinical Facilitator, Clinical methods, Undergraduate Medicine

PROFESSIONAL MEMBERSHIPS

- 2014-present CFPF Section of Researchers
- 2013-present Canadian Association for Medical Education (CAME)
- 2012-present An International Association for Medical Education (AMEE)
- 2007-present College of Family Physicians of Canada (CFPC)
- 2005-present Ontario Medical Association (OMA)
- 2005-present Canadian Medical Association (CMA)
- 2004-present College of Physicians and Surgeons of Ontario (CPSO)

PUBLICATIONS

- 2008 **Saadia Hameed**, Comment on a scientific paper, Focus magazine, July 1 2008
- 2014 **Saadia Hameed**, Editorial on importance of supporting mentally ill patients in the community. London Link. 2014 Sep 1, 4. (4) The Creative Workshop
- 2014 **Saadia Hameed**, Editorial on importance of education for all especially women in developing countries. London Link. 2014 Dec 1, 4. (5) The Creative Workshop,

PRESENTATIONS

ABSTRACTS

- 2014 Psychotherapy in Family Medicine. Canadian Collaborative Mental Health Care Conference Canada. 2014 Jun. **Presenter**
- 2012 Psychotherapy in Family Medicine, Trillium Research Day, Toronto, Ontario, Canada, 2012 Jun 6, Conference Presentation. **Presenter**

POSTERS

- 2014 Family Physicians' needs around psychotherapy training. Family Medicine Forum. Quebec City, Quebec, Canada. 2014 Nov
- 2014 Current state analysis of open access at an academic family medicine teaching unit, Trillium Research Day, Toronto, Ontario, Canada, 2014 May 28

PRESENTATIONS

Local

2011- present Presenters: Dr. **Saadia Hameed**, Dr. Tanya Thornton, *Advance Patient Centered Medicine*, Department of Family Medicine Western University, Ontario, Canada, 2012 Nov, Mandatory Academic Teaching, **Presenter**

Regional

2014 Presenters: Dr. **Saadia Hameed**, Chronic Opioid Prescribing: A practical approach, Annual Clinical Day (Citywide Department of Family Medicine), Ontario, Canada, 2014, Conference Presentation, **Expert**

2011-present An Approach to Opioid Prescribing for Chronic Non Cancer Pain, London, Ontario, Canada, 2012, Workshop, **Expert**

National

2015 Collaborating with the Globe and Mail for an article on mental health services in Ontario as an expert. This will also be accompanied by a short video report, The Globe and Mail, Ontario, Canada, 2015 Feb 1, Media Appearance, **Expert**

2014 Office processes facilitating responsible chronic opioid prescribing, Family Medicine Forum, Quebec City, Quebec, Canada, 2014 Nov 22, Conference Presentation, **Presenter**

International

2015 Psychotherapy and Mental Health and Addictions Policy in Ontario, International Mental Health Congress, Lille, France, 2015 Apr 28, Abstract accepted, **Presenter**

RESEARCH

2015 **Co-Investigator Saadia Hameed:** A Randomized Controlled Trial to Evaluate Early Intermittent Intensive Insulin Therapy as an Effective Treatment of Type 2 Diabetes: RESET IT Main Trial”, PI - Dr. Stewart Harris.

2015 **(PI), Saadia Hameed:** Knowledge of Family Medicine Residents around Prenatal Screening and Its Related Ethical Issues, A Qualitative Study with co-investigator Dr. Adeela Arooj R1

2014 - 2015 **Co-investigator Saadia Hameed:** Patient centered interprofessional shared care model for low back pain management study, PI-Dr Chris Bailey, (Proposal rejected)

2013-present **(PI) Saadia Hameed:** Needs assessment of FM residents around Motivational Interviewing, Supervising a resident in a needs assessment project around Motivational Interviewing skills in Primary Care - ongoing

2012 - 2013 **Supervisor:** Adult Onset Anorexia Nervosa, Supervised the systematic review by my resident Dr Alla Osadchy R2

2011 - 2012 **(PI), Saadia Hameed:** Diagnosis and management of patients with chronic kidney diseases in a primary care setting, Chart audit looking at

- the incidence of CKD III and IV in a primary care practice and its management and referral trends. Shvan Korsheed PGY2
- 2011 - 2012 **(PI), Saadia Hameed:** Family medicine residents' perceptions of the effects of ionizing nuclear radiation and advocacy, Qualitative Research. Resident Eugenie Waters PGY2
- 2010-present **(PI), Saadia Hameed:** Smoking Cessation counselling practices in Family doctors and Family Medicine residents, This is a survey Resident Divya Garg PGY2.
- 2008-present Psychotherapy in Family Medicine, This is my thesis title for the Masters in Clinical Science (FM) at UWO. supervisors Drs. E Vingilis, L. Lewis and Stephen State. Submitted April 2015

LEADERSHIP AND COMMITTEES

- 2015 **Member, Collaborative Care conference planning committee,** Departments of Family Medicine and Psychiatry
- 2013-present **Chair, Committee for implementation of Mental Health Program** at St. Joseph's family medical center.
- 2012-2013 **Chair, Implementation committee for Quality Improvement (Open-Access)** for SJFMC
- 2012-present **Member, Department Research Committee,** Department of Family Medicine, Western University, London Ontario
- 2012 **Member, DRC Sub-committee** to select best published article for submission to CFPC (award for best published article)
- 2011-present **Elected Member, Department Finance Committee,** Department of Family Medicine, Western University, London Ontario
- 2010-present **Member, Undergraduate Medical Education Committee,** The Schulich School of Medicine and Dentistry, Western University
- 2009 **Super user of EMR** – leadership in implementation of EMR at SJFMC
- 2008-20115 **Member Department Undergraduate Medical Education Committee,** Department of Family Medicine, Western University, London Ontario
- 2008-present **Interviewer, Post Graduate Residency Candidates,** Department of Family Medicine, Western University, London Ontario

CERTIFICATIONS

- 2015 Diploma in Practical Dermatology, Cardiff University, UK (expected)
- 2013 Certificate in methadone prescribing, CAMH, Toronto, Ontario
- 2012 L.E.A.P, London Health Sciences Centre, Palliative Care Course, London, Ontario, Canada
- 2012 Crucial Conversations, SJHC, London, Ontario
- 2012 Methadone Exemption, CPSO, License, 82874, London, Ontario, Canada
- 2007 Member, College of Family Physicians of Canada, Toronto, Canada
- 2008 Personality Dimensions, leadership development workshop

- 2006 NRP: Neonatal Resuscitation Program, Western University, London, Ontario
- 2005 ACLS: Advanced Critical Life Support workshop, Western University, London Ontario
- 1997-1998 Certificate in French Language, National University of Modern Languages, Rawalpindi, Pakistan