MENTAL HEALTH COUNSELLING IN FAMILY HEALTH TEAMS: 
A NARRATIVE INQUIRY

by

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A thesis submitted in conformity with the requirements 
for the degree of Doctor of Education

Graduate Department of Applied Psychology and Human Development

Ontario Institute for Studies in Education

University of Toronto

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Mental Health Counselling in Family Health Teams:
A Narrative Inquiry

Doctor of Education, 2016
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Abstract

The purpose of this study was to examine the experiences of seven mental health counsellors as they come to understand counselling within a family health team setting. Semi-structured qualitative interviews were held with each participant and a narrative analysis yielded meta-themes of professional background, professional practice and interprofessional practice which aided in formulating an integrative model of mental health counselling within this setting. In conceptualizing counselling in this setting, participant told stories of facilitators and barriers to providing care and the process by which they came to understand these dynamics. Systemic issues of hierarchy in medicine and funding models are also discussed. This study adds to the discussion on mental health counselling in family health teams in southern Ontario and provides additional insight into recommendations for counselling practice within interprofessional teams.
Acknowledgements

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Chapter One: Introduction

A Shifting Health Care Context

In recent years, government cutbacks and the need for more cost-effective spending have put pressure on the Canadian healthcare system to prevent waste and improve services. Shifting the approach to healthcare from one that employs experts who have ultimate decision-making and spending powers to treating individual patients as consumers who have responsibility over their own care is one way of contributing to this change. This shift in perspective has brought forth a new approach to healthcare: interprofessional collaborative care. Briefly defined, interprofessional collaborative care is healthcare provided by multiple professionals, from a variety of medical and non-medical backgrounds, who share information and collaborate on decision-making regarding a patient’s health and social concern(s) (Canadian Interprofessional Health Collaborative, 2010). Within an interprofessional collaborative care context, patients are encouraged to gain a sense of ownership over their own health by developing collaborative relationships with multiple healthcare providers. Having multiple healthcare professionals available to patients may prevent unnecessary or redundant care. Interprofessional collaborative care also has the added benefit of allowing patients to access specialized services within general practice settings. This approach helps to close the gap between generalist and specialist service and may, in turn, improve the quality of patient care.

Presently the Canadian Medical Association (2007) acknowledges the need for interprofessional collaborative care. Although collaborative interprofessional care occurs within a variety of healthcare settings, the focus of this dissertation is on family health teams. Primary healthcare is usually the first point of contact that patients have with the healthcare system. In past decades, primary healthcare was provided by a family doctor who worked as a sole
proprietor and provided individual care to patients having a variety of needs. When patients required specialized care—that is, care beyond the scope of practice of the family doctor—they would refer patients to specialized services that have been largely located within hospitals or specialized clinics. While such referral practices still occur today, healthcare reform is necessitating that these referral practices be further analyzed since particular types of care, such as mental health care, are often not best served within these specialized settings or could be better served within the family doctor’s practice.

An increasing number of patients are going to their family doctor reporting concerns related to mental illness (Kates, George, Crustolo, & Mach, 2008). The increasing phenomenon of mental illness in primary care patients makes this a necessary point of study. This study examined mental health and mental illness in primary care due to the increasing importance of the topic. More specifically, it examined counselling within family health teams and the nature of the new role of mental health counsellor. In the past decade, counselling has become an integral part of primary health care. Despite this development, little research has been conducted documenting how this role is experienced among mental health counsellors. Counsellors within this context are seen as a vital addition to health care (Brettle, Hill & Jenkins, 2008; Kates, Crustalo, Farrar, & Nikolaou, 2002; Firth, 2010; Sibbald, Addington, Hall, Brenneman, & Obe, 1996; van Deventer, Couper, Wright, Tumbo, & Kyeyune, 2008).

It is important to note that not all primary health care settings practice interprofessional collaborative care. In Ontario, for example, the model of care where interprofessional collaborative care exists is referred to as a family health team to differentiate the type of patient care within the primary care context (Government of Ontario, 2012). This research project refers to interprofessional primary care as a family health team. Thus, “primary care” refers to the level of care and “family health team” refers to the model of care practiced within the setting.
Mental health is increasingly recognized as being a vital component of health and wellbeing in Canadian society (Health Canada, 2002). Locating mental health services within a primary care setting allows for general practitioners to deal with more complex mental health problems within their practice and, according to Firth, thereby prevents patients from “falling through the cracks” (2010). Locating mental health services within primary care reduces barriers to accessing care and serves the interests of patients who want to access these services within their family doctor’s office. Moreover, locating mental health care within primary care also serves the interests of many physicians who recognize the increasing need to provide mental health services to their patients (Clatney, MacDonald, & Shah, 2008). Mental health service providers also tend to acknowledge the need for implementing these services within primary care (Dennis, 2007). With every physical ailment that is seen within family practice there are also associated psychological or social issues, as illustrated by the following quote:

To be a medical practitioner is this environment requires a substantial tolerance of uncertainty. For those living in the dichotomized world of physical versus psychological explanations of phenomena, this picture can lead to a misstatement that is common in the literature of behavioral health needs in primary care that 70% of visits to primary care are for problems that are psychosocial in nature (Gunn & Blount, 2009, p. 238).

Alternatively, there is evidence that many people who are living with mental illness also have physical health concerns that need to be addressed (Dennis, 2007). Providing mental health care within primary care thus promotes overall health by serving to bridge gaps in service.

Interprofessional collaborative care in the form of family health teams make it possible to provide mental health services within primary care settings (Kates, 2008; Kates et al., 2011). Making psychiatrists, psychologists, and counsellors part of the interprofessional team provides support to the family physician and may, in turn, increase the safety and effectiveness of health care.
The role of counsellors in Canada is diverse (Gazzola & Smith, 2007). Counsellors across Canada lack a cohesive identity since counselling is provided by a variety of professionals from diverse academic backgrounds. Counsellors who work within primary care also lack a sense of identity (Gershin, 2008) and the role of counsellors within family health teams is very eclectic. As the nature of the role of counselling in primary care differs across practice settings and geographical locations, it is difficult to define what counselling is within a primary care context.

The profile of a typical counsellor in primary care has shifted from a psychiatric nurse with medical training to someone who is a non-medically trained social worker, counsellor or psychotherapist with various possible educational backgrounds, such as counselling, psychology, social work, and marriage and family therapy. This symbolizes that values in healthcare have shifted from a modernist, disease orientation to a post-modern holistic orientation. Research that views counsellors as ideal informants is needed to illustrate the impact of this shift. All members of a family health team, including family physicians, nurses, pharmacists, dieticians, and respiratory therapists, work together to provide patient care. In an ideal family health team setting, all members should become involved when working with patients with mental illness.

Statement of Purpose

There are two central reasons why this research is important. First there exists a lack of Canadian specific research documenting the lived experiences of counsellors who are employed within primary care settings and family health teams. Canadian research thus far has been written from the perspective of medical providers and has paid limited attention to the stories of mental health service providers. Second, much Canadian policy has been developed to describe the rationale for collaborative care and how to implement care; however, these policies lack specific direction as to how collaborative care should operate within variable family health team contexts.
In addition, these policies lack specific direction about how to practice mental health service provision within the family health team environment.

Furthermore, this research project is essential because it contributes to existing research on how setting influences practice (Chong, Aslani, & Chen, 2013; Foster, 2000; Hall, 2005). In particular, this project adds to the discussion on how working within a medical model of mental health influences counsellors’ understanding of their practice. This research provided an opportunity for counsellors to assert and explain their role within the context of the family health team.

**Research Question**

This research concerns intersections of mental health counselling in family health teams. Specifically it focused on how counsellors come to understand their stories of providing counselling services within interprofessional collaborative primary health care settings. Seven mental health counsellors who worked in family health team settings in various locations in southern Ontario were interviewed about their experiences of providing services in this model of care and setting. The research questions are twofold: How do the experiences of mental health counsellors working in family health teams help inform counselling practice? And how can understanding these experiences create a comprehensive understanding of mental health counselling within a family health team context?
Definition of Terms

There are several terms that need to be explicated for the purposes of discussion. The following terms are used throughout this dissertation:

**Mental health and mental illness.** For the purposes of this research, mental health is defined as:

A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community (World Health Organization, 2010, p.1).

This definition implies that mental health is more than the absence of mental illness since it addresses multiple factors beyond biology or disease.

In the past, mental illness was widely defined according to the set of disorders outlined in Diagnostic and Statistical Manual of Mental Disorders - 5th edition (2013).

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities (DSM-V, 2013, p. 20).

However, the concept of mental illness is continually changing. This research project used a more comprehensive definition of mental illness and recognizes that mental illness may also be:

associated with rapid social change, stressful work conditions, gender discrimination,
social exclusion, unhealthy lifestyle, risks of violence and physical ill-health and human rights violations. There are also specific psychological and personality factors that make people vulnerable to mental disorders. Lastly, there are some biological causes of mental disorders including genetic factors and imbalances in chemicals in the brain (World Health Organization, 2010, p.1).

The above quotation emphasizes that mental illness can be shaped by social factors. It is in this respect that it is also important to recognize the social determinants of mental health. Furthermore, a diagnostic classification of mental illness can lead to further marginalization of people who are living with mental illness.

**Primary care, primary care providers and family health teams.** Primary care is referred to as the entry level of care provision within a healthcare system. Primary care is often the first point of contact for a patient who requires non-urgent health services. A family health team is a relatively new healthcare model in which an individual or family receives medical services from a family doctor and other allied health professionals, including nurses, pharmacists, counsellors, and dieticians. The individuals, including the doctor, who make up this setting, are referred to as a family health team. Family doctors are also referred to as primary care providers since they are deemed the most responsible for healthcare. Other terms for primary care are primary healthcare, general practice, family practice, and the patient home. This research focused specifically on family health team settings in southern Ontario.

It has been stated that Ontario’s family health team model, created in 2005, is quite possibly the largest family health team network in North America with approximately 2 million persons served by what will soon be 200 family health teams; this is an increase from 170 between 2005 to 2010 (Rosser, Collville, Kasperski, & Wilson, 2011). This model was developed
in reaction to the healthcare crisis in Canada. The Ontario government proposed the following action plan which includes three goals: “1) keep Ontarians healthy, 2) faster access and stronger links to family health care, and 3) the right care, at the right time and right place” (Government of Ontario, 2012, p.1). The government sees family health teams as “the hub” of healthcare services (Government of Ontario, 2012, p. 8). This means that this setting serves as a location for the coordination and integration of services and is intended to lessen the burden on the healthcare system and provide better care to patients.

**Interprofessional collaborative care.** Previously referred to as “shared care,” collaborative care refers to both medical and non-medical care that is provided by a variety of members within a primary care setting. Collaborative care is also referred to as interprofessional care or integrated care. These terms will be used interchangeably in this thesis. In this new healthcare model, the individual or family seeking treatment is at the centre of care and all members are seen as equal partners working together to promote health. A collaborative health care system is more flat-lined in structure and differs from past healthcare models in which family doctors were seen as having ultimate authority and expertise over their patient. This new approach to healthcare empowers individuals to become experts regarding their health and wellness.

**Counselling and mental health counsellors.** There are diverse definitions of counselling in the literature. This research project focused on the practice of mental health counselling within family health teams. It defined counselling as the action of providing support to and treatment of individuals and families with regards to mental health, mental illness and other life issues. Within a primary care model, mental health counselling is provided by people from a variety of professional backgrounds including, for instance, social workers, psychiatric or mental health
nurses, marriage and family therapists, psychotherapists, and counsellors. For the purposes of this research project, these professionals are collectively referred to as mental health counsellors to keep consistent with current Canadian research (Kates, 2011).

Mental health counsellors all have at least a Master’s degree in their profession and are either regulated under the Registered Health Professionals Act (for example, Registered Social Worker) or else certified under a provincial or federal regulatory body (for example, the Canadian Counselling and Psychotherapy Association). It is interesting to note that there has been a shift in primary care from hiring those from a psychiatric nursing background to now hiring professionals who have come from non-medical backgrounds such as marriage and family therapy and/or counselling psychology.

Summary

After interviewing seven mental health counsellors who have worked in family health teams, counsellor narratives were analyzed and themes emerged that addressed topics related to professional background, professional practice and interprofessional collaborative care. A larger discussion emerged regarding the current challenges that mental health counsellors face in the larger health care system in Ontario. The research results provide insight into issues related to mental health service provision within collaborative interprofessional health care settings. These results will help inform government policies regarding mental health services in family health teams. The study also served to aid new and current mental health counsellors by providing insight into effective service provision within family health team environments and recommendations for best practices.

The following review of the literature describes the current state of mental health services in Canada, the need for implementation of mental health services in primary care settings, the
formation of family health teams in Ontario, and the new role of mental health counselling in this setting. Subsequent chapters outline the research methodology, as well as within and between participant results that yielded meta-themes of professional practice, professional background and collaborative interprofessional care within the current healthcare system in Ontario. Finally, the findings are discussed with relation to implications and recommendations for policy development and clinical practice.
Chapter Two: Literature Review

Over the past five years the family health team narrative has shifted from a positive idealized version of health care to a model that's value is being questioned. This chapter addresses issues faced by mental health counsellors working in family health teams in Ontario. In understanding these issues it is essential to also understand the history of mental health care in Canada in order to fully grasp the context of service provision. The following literature review includes the history of mental illness in Canada, the increase in demand for mental health care services, the increased recognition of mental health concerns in primary care settings and the need to fill in gaps to existing mental health care through the creation of interprofessional collaborative care teams. In addition, the literature on the governmental priority of healthcare reform and the creation of family health teams as well as the new role of mental health counsellor within these teams is presented. The topic of mental health counselling in Canada is a relatively new. In conducting this review the researcher has also chosen to review studies and reports from other countries where interprofessional collaborative primary mental health care has a longer history of practice. These include the United Kingdom, Australia, and the United States.

Canadian Mental Health Care

It is well known that mental health has been deemed a priority in Canada’s health care system. The impact of mental illness has become an area of great concern across Canada largely in reaction to the increasing incidence and prevalence of reported mental illness combined with the lack of governmental concern.

The lengthy Romanow Report (2002) caused great attention when it only made minimal reference to mental health within the context of home and community healthcare in Canada. This report emphasized a Canadian vision for health care with recommendations for moving forward in the future. The report addressed concerns of an aging population, a priority for aboriginal
health, and the need for prevention and a more accountable health care system. It also had the goal of making Canadians the “healthiest in the world” but did not include mental health in this vision. When the report did discuss mental health it referred to it as “the orphan child” of healthcare and described mental healthcare as being the responsibility of homecare and community rather than the medical institutions. It is partially in reaction to this report that mental health has been recognized as an essential part of healthcare systems. The reaction from the health care community gave light to what would be now a governmental priority.

After the publication of this report, the Mental Health Commission of Canada was formed and released a strategy for Canada titled Changing Directions, Changing Lives (Mental Health Commission of Canada, 2012). The commission called for changing the mental health care system and proposed the following six strategic directions:

1. Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible.
2. Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights.
3. Provide access to the right combination of services, treatments and supports, when and where people need them.
4. Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners.
5. Work with First Nations, Inuit, and Métis [people] to address their mental health needs, acknowledging their distinct circumstances, rights and cultures.
6. Mobilize leadership, improve knowledge, and foster collaboration at all levels.

(Canadian Mental Health Commission, 2009, p.13)
The Mental Health Commission of Canada, following a review of the literature, concluded there was a need to integrate mental health services within primary care (Jefferies et al., 2013). The authors of this review of the research on mental health and substance abuse issues in primary care settings discussed the need for primary healthcare reform to address the increasing needs of persons with mental illness. This reform was needed due to the lack of psychiatric services available within communities.

Other reports have also discussed the significant impact mental illness has had on Canadian society. A report from the Public Health Agency (2002) of Canada on mental illness noted the following:

- The onset of mental illness occurs for most individuals during childhood and adolescence and continues to affect them throughout their lives.
- There are significant economic consequences related to mental illness as can be seen in the fact that many individuals with mental illness live below the poverty level and have to access government disability programs in order to survive.
- Mental illness significantly impacts the healthcare system; notably, 3.8% of general hospital admissions are due to mental health disorders.
- Mental illness significantly affects families; caregivers often experience stress and burnout as well as social stigma.

(Public Health Agency of Canada, 2002)

This public health report illustrated the current negative impacts that mental illness has on Canadian society and therefore pointed to the need for research to help address these concerns. In addition, this report highlighted the importance of providing quality mental health care services in Canada. It noted that primary care is often the first point of contact for a person with
mental illness and thus it is necessary to train and support family physicians in the task of providing assessment and treatment of people who are living with mental illness. This report thereby emphasized the need for integration of mental health services within primary health care settings since such integration may provide quicker access to care.

**Examining the Need for Mental Health Services in Primary Care**

Research affirmed that there is an increasing need for mental health services to be provided within primary care settings (Baron, Lattie, Ho, & Mohr, 2011; Dennis, 2007; Jefferies, et al., 2013; Kates, Crustolo, & Mach, 2008). A review of the literature illustrated why it makes sense to locate mental health services within primary care settings. It also illustrated why a role of mental health counsellor is needed to help address this increased demand. The following section describes the rationale for locating mental health services within primary care settings.

The first reason why mental health services should be incorporated in primary care is due to direct and indirect demands for mental health services. Directly, more people are coming into primary care settings reporting mental health concerns. People are choosing to disclose mental health concerns to their family doctor and most people see this physician as the first point of contact when addressing their mental health related concerns (Public Health Agency of Canada, 2002). Indirectly, mental health concerns become apparent when symptoms occur which are medically unexplained (Katon & Walker, 1998). A further rationale for incorporating mental health services within primary care is to support family physicians through creating opportunities for increased awareness and education about mental health and mental illness. While mental illness is an increasingly reported health problem, not all primary care providers are aware of this increase (Dennis, 2007). Many patients come to see family doctors with medically unexplained symptoms. Very often these symptoms are a byproduct of mental health issues (Katon & Walker,
Patients repeatedly visiting for symptoms that cannot be explained by physical causes often frustrate primary care providers. A greater awareness of mental illness among physicians is needed so that these patients are able to access care.

In a British literature review of primary care mental health services, Dennis (2007) explored the impact of mental illness on primary care practices. This article highlights the importance of primary care providers gaining greater awareness of the link between mental illness and physical ailments. Furthermore, this review emphasized the need for primary care providers to promote mental health and to combat discrimination. Possible treatments for mental illness are also explored; including the use of psychotropic medications in combination with “talking therapies such as cognitive behavioral therapy, counselling and psychotherapy” (Dennis, 2007, p. 3). Dennis (2007) maintained that mental health care should include the primary care provider and not ultimately remain the responsibility of a mental health specialist. Because of the increasing number of mental health concerns, it is important for everyone within primary care to become understanding of how best to support persons living with mental illness. This shared approach encourages physicians to share leadership of mental health care.

Another reason to locate mental health services within primary care is to better support physicians in dealing with complex mental health issues. The literature pointed to cases where patients with mental health issues seen in primary care are just as complex as those patients served in tertiary clinics or hospitals. In a Canadian study, Kates, Crustolo, and Mach (2008) discussed the variety of patient mental health concerns in a primary care setting. This survey of an Ontario-based primary health care network focused on people with varying degrees of mental illness from mild to severe. The authors randomly surveyed 10% of patients of both outpatient (n=370) and primary care (n=262) settings using the Colorado Client Assessment Rating, a measure that assesses strengths and mental health impairments in 26 domains related to
symptoms, behaviours and level of social and community functioning. The outcome of this study suggested that presenting problems in people seeking mental health care in primary care are similar to outpatient hospital clinics in that patients often come to these settings with severe and persistent mental illness. Furthermore, the study noted that those with severe and persistent mental illness are often served within primary care which emphasized the need for enhanced psychiatric care within these settings. Primary care settings have clearly played an integral part in a community’s mental health network. It is thus vital to have skilled mental health practitioners working in these settings.

Another reason to locate mental health services within primary care is due to patient preference (van Deventer, Couper, Wright, Tumbo, & Kyeyune, 2008). While more research on patient experience in primary mental health care is needed one article discussed patient interest reporting. In this US study, Baron, Lattie, Ho, and Mohr (2011) surveyed consumers of primary care services regarding their interest in receiving mental health services. In this study the authors reported that patient interest was high.

Another reason to locate mental health services within primary care is to increase access to mental health services. Baron et al. (2011) further reported that, while patient interest was high, utilization rates were low due to a variety of barriers, including the high cost of accessing mental health services, the stigma surrounding mental illness, and not knowing how and where to access services. This study suggested that more must be done to reduce barriers to care. Providing these services in primary care settings is one way of increasing accessibility to mental health care.

A final reason to locate mental health services within primary care settings is due to the lack of available psychiatric services and in particular the shortage of available psychiatrists. In the past physicians could refer patients living with mental illness to outpatient psychiatrists. This referral practice is no longer the norm. Currently, there is a decline in the number of psychiatrists
available to assess and diagnose mental illness. At times the literature suggested that the field of psychiatry is in crisis, either due to the lack of medical doctors choosing psychiatry as a specialty or the evolution of the antipsychiatry movement. For example, Katschnig’s (2010) article on a review of psychiatry from a global perspective asked the question “are psychiatrists an endangered species?”. Katschnig (2010) discussed both internal and external challenges faced by those in the profession, including decreased confidence in diagnostic and classification systems. The article also noted that a lack of coherent theoretical basis may contribute to the “splitting” of the profession into subspecialties. There also existed the issue of psychiatry being absorbed by other professions. Katschnig (2010), for instance, discussed external challenges to the psychiatric profession, such as competition from other professions, including general practitioners, neurologists, and psychologists who can also provide diagnosis and treatment. Another challenge reported was client discontent which can be seen in the formation of the “psychiatric survivor” movement and in persons with mental illness who report victimization due to the psychiatric diagnostic and treatment system.

A recent profile of psychiatry in Canada further endorsed this decline (Buske, 2012). A bulletin released from the Canadian Collaborative Centre for Physician Resources stated that as of January 2012 there were 4,426 licensed psychiatrists in Canada. Notably, psychiatry had a disproportionately large number of older physicians compared to other disciplines in medicine. It was estimated that by 2030 there will be the need for 300 more psychiatrists than are presently anticipated to enter the field. This article pointed to the need to expand psychiatry training programs in Canada or to provide mental healthcare through alternative means such as mental health counselling in family health teams. While psychiatrists are sometimes available for consultation within primary care settings, many settings do not have access to this service. It then
becomes the task of the team to utilize other professional resources in order to help assess and treat mental health issues within primary care settings.

The research on locating mental health services within primary care settings may explain why Canadian policy makers were quick to advocate for collaborative mental health care and the creation of family health teams. The collaborative care context is the next point of discussion in this literature review.

Health Care Reform and the Collaborative Care Context

Collaboration within healthcare provides one means of addressing the need for healthcare reform. It also points to a different dynamic impacting a mental health counsellor. Collaborative care can reduce barriers to accessing care for persons with mental illness. Particularly with regards to mental health services, an interprofessional collaborative approach often increases accessibility to support and treatment and reduces stigma (World Health Organization, 2008). Collaborative interprofessional primary mental healthcare takes place within what are now referred to in Canada as family health teams. In this context, mental health counselling takes place within a team; it not only relies on team input but also provides valuable information to the team.

Ontario Family Health Teams. In 2005, Ontario created an interprofessional collaborative care model called a Family Health Team. Since then 184 family health teams have been created in Ontario through five waves of implementation. A call for proposals for the creation of family health teams was conducted from 2005 to 2010 with the last 50 family health teams installed in 2012 (MOHLTC, 2014). There are currently no opportunities to expand family health teams in Ontario as the call for proposals has closed. Ontario has currently the greatest number of family health teams per capita in North America serving approximately 3 million individuals (MOHLTC, 2014). The main function of a family health team is to improve access to
services through collaborative interprofessional health care. There exists an inherent assumption that a Family Health Team model is an interprofessional collaborative health care model.

**What is collaborative care and how is it practiced?** Collaborative interprofessional care represents a shift in philosophy and approach to care from one that is top down in which the family doctor is the expert and is in charge of care to one that is more flat lined and focused on strengthening the patient’s capacity for change.

At the forefront of this model is the concept of “patient-centred care” (College of Family Physicians of Canada, 2009). The Ontario Medical Association defined patient-centred care as “a system where one can move freely along a care pathway without regard to which physician, or other healthcare provider, institution, or community resource they need at the moment in time. The system is one that considers the individual needs of patients and treats them with respect and dignity” (Ontario Medical Association, 2010, p.34). Collaboration among healthcare providers, physicians and community resources is important in order to help fulfill the goals of this definition. The person who is at the forefront of this model is the patient. This idea represented a shift from earlier practice where the family physician was allotted the most authority over patient care. However, it is important to note that the physician is still considered more responsible and the most liable for patient care in relation to other members of the collaborative team. Also, the Ontario Medical Association (2010) importantly notes that this concept is rather tenuous since it is unclear if patient-centred care always privileges the needs of patients.

The College of Family Physicians of Canada (2009) furthermore identified the family doctor’s office as the patient’s “medical home.” A medical home is a patient-centred medical care setting where patients have a personal family physician that provides and directs their medical
care. The care that is provided is considered holistic in that it takes into account both medical and non-medical approaches to health and illness. The medical home can occur within the context of a family health team but is meant to encompass all family practice offices. In the case of a family health team, the medical home uses continuous and comprehensive coordinated care and patients have access to an interprofessional team. Interprofessional teams often consist of physicians, nurses, occupational therapists, pharmacists, mental health counsellors, and psychiatrists. Patients also have advanced access, meaning that they can seek care right away without having to wait days or weeks for an appointment. Medical records are electronic and secure.

In a primary care model, the family physician’s office is where one should go for all non-urgent healthcare issues, including mental health care (College of Family Physicians of Canada, 2009). The family physician decides where the patient should be referred to and still remains the main referral source; however, other allied health professionals, such as mental health counsellors, can also refer on the physician’s behalf.

The phrase ‘medical home’ implies that patients should feel at home in their family doctor’s office. It is interesting to note that policy papers and discussions on the patient’s medical home contain little mention of other providers’ points of view, such as their experiences providing care within this new setting. There is also limited research on whether the present healthcare system in Ontario actually provides a ‘medical home’ for patients or if this is an ideal to strive towards.

There is currently a lack of consensus regarding a comprehensive definition of collaborative care. In one US study, researchers conducted two to three interviews with two primary care physicians, five psychotherapists, one nurse, one office manager, and five patients (Todahl, Linville, Smith, Barnes, & Miller, 2006). During the initial interview they used open-ended questions; they asked “what is collaborative care?” and, more specifically, “what occurs?”
in a collaborative care setting and “how it is experienced?”. They asked more specific questions in subsequent interviews. Data was analyzed using the Spradley method of domain analysis where semantic relationships are decoded from data. Findings from this study identified the following themes: characteristics of the environment; therapist characteristics; referral processes and characteristics of collaboration. These themes reflected beliefs participants had about either providing care or receiving care within this setting. Therapists believed that a patient’s trust of physician transferred onto the therapist when the physician referred to them. Also therapists believed that when a patient saw psychotherapy as part of a prescription from their physician the therapy experience was likely enhanced and patient attendance was improved. This illustrates the need for collaboration. Collaboration was described by both physicians and therapists as “an essential opportunity to strategize, particularly regarding diagnosis and treatment planning” (Todahl et al., 2006, p 54). Both physicians and therapists felt that collaboration occurred and that it was needed to enhance patient care. The collaboration was mostly spontaneous but meetings were scheduled when acute issues arose. This study’s findings indicated that collaboration increased therapists’ awareness of medical issues and physician’s awareness of psychological issues.

One Canadian position paper from the point of view of psychiatrists and physicians defined collaborative mental health care as “care that is delivered by providers from different specialties, disciplines, or sectors working together to offer complimentary services and mutual support” (Kates, et al., 2011, p. 2). The authors maintained that primary mental health care should be built on personal contacts and is based on mutual respect, trust and recognition of each partner’s potential roles and contributions. It also relied on effective practices that are both evidence and experience based, and responsive to the changing needs of patients, their families and caregivers. Furthermore, mental health care is shaped by the context and culture in which this
care takes place and it is responsive to local resource availability and the skills and interests of participating providers.

**Challenges to collaborative care.** Although it is well documented that collaborative care is a necessary element within primary mental health care systems (Kates et al., 2011; Collins, Levis, Munger, & Wade, 2010; CMA, 2007; Pauze & Gagne, 2005), there has existed many challenges with implementing services (Beacham, Herbst, Streitweiser, Scheu, & Seiber, 2012; Gunn & Blount, 2009; Kessler, 2008; Fickel, Parker, Yano, & Kirchner, 2007; Madson, 2009; van Deventer, Couper, Wright, Tumbo, & Kyeyune, 2008; Urada et al., 2012). Various difficulties may arise when beginning a collaborative care program. Challenges also come in the form of barriers to providing care and conflict that may exist between professionals who are doing collaborative work.

In a Canadian review of collaboration in healthcare settings, Hall (2005) outlined three main barriers that may impede collaborative interprofessional practice. These barriers are termed educational, systemic and personal. Hall stated that educational systems impact the professional’s development of a “cognitive map and further mortars the walls of the professional silo” (p. 191.). This specialization in education can make collaboration difficult. System barriers also impact collaboration. For example, certain professionals have less power within the healthcare system as can be seen in the classic example of the power differential between nurses and doctors. Furthermore, personal barriers also impact interprofessional collaboration. For instance, each profession tends to attract persons with certain personality characteristics and these differences may pose a barrier to collaboration.

Collaboration among various professions may also be challenging when it comes to working in mental health care. In an Australian qualitative study, Chong, Aslani, and Chen (2013) examined mental healthcare providers’ perceptions of barriers and facilitators to both
shared decision-making and interprofessional collaboration in mental health care. Healthcare providers were recruited from a variety of settings, including mental health units in hospitals, GP practices, hospital pharmacy departments and community pharmacies. In-depth semi-structured interviews were conducted consisting of open-ended questions about the involvement of mental health consumers/patients in decision-making, interprofessional collaboration in mental health and medication adherence. Notably, the researchers were pharmacists with experience in providing mental healthcare. Results from the interviews showed the following barriers in two main themes: factors associated with healthcare providers and factors associated with the healthcare industry.

Chong et al. (2013) explained that the participants from non-medical backgrounds (pharmacists, nurses and occupational therapists) felt that collaboration among them was valued. However, they did not feel that their collaboration with physicians and psychiatrists was valued which reflected the dominance of conventional medical models that undervalue input from non-medical providers. The second theme of environmental/system factors referred to perceived external barriers such as organizational and healthcare system barriers. Organizational barriers included issues with information sharing as well as lack of leadership. Chong et al. (2013) also discussed how lack of healthcare resources and policies may indirectly inhibit collaboration. The findings of this study illustrated how setting can influence practice. For example, if health care providers are unable to voice concerns about a client to their team because of issues with communication, this could put the patient’s safety in jeopardy. Moreover, if the professional role is undervalued by the team then any provided advice may be ignored.

Other challenges may exist when implementing mental health counselling services in collaborative interprofessional primary healthcare teams. In a US study surveying physicians in primary care, Beacham, Herbst, Streitwieser, Scheu, and Seiber (2012) found that when
physicians lacked knowledge about mental health counselling services, they did not find the services necessarily helpful. This study defined helpfulness as that which aided in providing services to a physician’s practice. This study highlighted the need to educate physicians about the role and scope of practice of mental health counsellors. The study used two samples of primary care providers. The first providers surveyed (n=31) were from settings where access to integrated mental health services was available. The second group of participants surveyed (n=62) did not have access to integrated mental health services. Findings of this study indicated that providers who did not have access to mental health services within their practice setting were not likely to see the benefit of having these services integrated within their office. Beacham et al. (2012) speculated that this view may exist because primary care providers have always coped on their own and have referred patients outside of their practice setting for mental health care. Conflict may result should the model be imposed upon a physician who views the addition of other professions in their practice as unnecessary or unhelpful.

Additional challenges can occur when integrating medical and non-medical professionals. Clinical psychologists, Gunn and Blount (2009), explained that differing treatment philosophies may cause conflict. Those working within a medical model may see the physician as the one with the ultimate responsibility for treating and curing the client. In contrast, in what Gunn and Blount (2009) term the “mental health world”, the patient (often referred to as the client) and the psychologist often shares responsibility for change. Counsellors, like psychologists, also come from a non-medical background and thus often have treatment philosophies which differ from medical providers. For instance, Gunn and Blount (2009) argue that whereas medicine is action oriented, counselling is process oriented. While patients have the expectation that their physician will “do something” to help them, in psychotherapy, the therapist guides the client towards greater self-discovery or change. Gunn and Blount (2009) also noted that different jargon is used
by physicians and counsellors. Psychologists may find medical language difficult to understand at first and will need to educate themselves on various terms. Similarly, the physician will need to become familiar with psychological language. These differences can create barriers to care. A transition period is needed in which both parties learn about the others’ approach.

Gunn and Blount (2009) explained that psychologists can overcome barriers to care by making a commitment to collaborate; develop relationships; practice flexibility, creativity and openness; and act like both a guest in the physician’s practice as well as one whose role is important to patient care. The psychologist must be willing to engage with a professional from a different background. They must take the necessary time to cultivate this relationship. It is essential that psychologists be creative, flexible and open so they do not appear threatening to physicians. Physicians may be accustomed to working as sole proprietors and may feel that their boundaries are being infringed upon if a psychologist appears too aggressive. At the same time, psychologists should recognize that their place within the practice is necessary and important to the function of overall patient health. Notably, the concept of acting like a guest suggests that tension may be felt within the practice and there may be a need to mitigate this tension through gradual collaboration (Gunn & Blount, 2009). Although the authors write from the point of view of psychologists, the above information is also relevant to mental health counselling more generally as both professions identify with non-medical conceptualizations of illness.

In another study, Kessler (2008), who is also a psychologist, called for greater education and information about both medical and psychological approaches to care. Kessler (2008) discussed the newness of the role and the positive and negative experiences associated with integrating and collaborating within primary care mental health teams. This article addressed the need for program planning within a collaborative care system. Kessler (2008) argued for greater awareness of context setting and notes that primary care sites are all unique and thus there is no
“one-size-fits-all” approach. Kessler (2008) also discusses the “deadly sins of integration” (2008, p.39), including inattention to design elements due to assuming that mental health care is the same in all settings; not recognizing that education and information, while necessary, are not sufficient to generate change; and failure to collect data and gather evidence regarding the effectiveness of the collaborative approach.

Kessler (2008) also indicated that there needs to be proper planning before implementation and integration. Furthermore, it is important to recognize that administrators and physicians may lack the time to do research or interest in reading more about current evidence. Finally, failure to collect data during implementation will make it difficult to sustain efforts from a financial and policy point of view. Programs rarely continue to receive approval and funding if evidence of outcomes remains undocumented.

An American study on mental health collaboration within primary care settings pointed to the need for more in-depth description of what collaborative care looks like (Fickel, Parker, Yano, & Kirchner, 2007). Fickel et al. (2007) found that there existed little evidence of collaboration within interprofessional teams and that what consultation does occur is often informal, meaning that it is unplanned and often takes place in impromptu hallway conversations or last minute meetings. Fickel et al. (2007) interviewed 22 participants (physicians and counsellors) from 10 outpatient facilities. While those surveyed indicated overall satisfaction with referral to mental health counselling, little evidence of collaboration was exhibited. The potential barriers that were identified to collaboration included inadequate staffing and lack of resources. Mental health counsellors in this study were more likely to identify barriers than physicians. The findings indicated that there was not enough staff to allow for collaborative time since staffing hours were mostly devoted to direct patient contact. Also, some counsellors were located in more than one setting and thus they were not always in close proximity to the physician which made
collaboration difficult. Furthermore, mental health counsellors reported that the large volume of referrals made it difficult to find time for consultation and collaboration.

In an unpublished American dissertation, Masdon (2009) examined the experiences of therapists and the referral practices of family physicians. This study highlighted the lack of referrals that licensed marriage and family therapists received and called for greater recognition of this service. Masdon (2009) also called for greater collaboration and recognition of the various forms of support available in the field of mental health primary care.

In another study, van Deventer, Couper, Wright, Tumbo, and Kyeyune (2008) examined the general dissatisfaction with mental health services in primary care and the need for healthcare reform. This study explored issues surrounding integration of mental health services into primary care and provided information for managers and clinicians to use in the improvement of mental health care. Patient dissatisfaction with services resulted from these issues. These issues included communication, lack of continuity of care, long waiting times, and resource constraints. With regards to the issue of patient noncompliance, van Deventer et al. (2008) suggested that perhaps the system needs to change rather than the patient.

Another study explored the importance of understanding the experiences and perceptions of staff members who are implementing collaborative care and how these experiences can help define challenges (Urada et al., 2012). Urada et al. (2012) surveyed mental health staff, front desk staff, primary care providers, nurses and physician assistants working within a primary mental health care setting. The 61 responses that were received indicated that although support staff and primary care providers valued the health care service, the support staff themselves did not have an awareness of this value. The mental health support staff was also less likely to agree that communication was good between support staff and primary care providers; they felt that primary care providers were less likely to share information or consult with them. This article highlighted
the need for further communication within collaborative care settings since communication, or lack thereof, significantly impacts the services mental health counsellors provide to their patients.

There has been minimal input on how mental health counsellors should integrate within family health team settings. One US review illustrated the importance of developing a relationship with the primary care physician. In this study, Bowling, Aitken and Curtis (2004) noted that it is essential for mental health counsellors who wish to work in integrative care settings to find ways to network with physicians. Bowling, Aitken and Curtis (2004) found that collaborative arrangements work when mental health professionals initiated or suggested collaboration. They stated that it is important for mental health counsellors to obtain licensure and be insurable. They maintained that mental health counsellors should secure grant funding to initiate entry into integrated care settings. Securing funding would not been needed in the current research context as currently in Ontario mental health counselling funding is allotted by the Ministry of Health and Long Term Services. They also emphasized the need for mental health counsellors to be skilled in providing brief treatment modalities so as to keep up with the pace of the primary care setting. Mental health counsellors should feel comfortable working with a broad range of issues and mental health disorders in a generalist capacity. Furthermore, a good working relationship with all members of the integrated team is essential. This can be facilitated through clear and concise communication as well as the maintenance of openness, flexibility and professionalism. Mental health counsellors must be comfortable working within a biopsychosocial model that included having familiarity with medications and keeping up-to-date on pharmacological treatments for mental health disorders. Furthermore, case management skills are needed in order to link patients to other services. Mental health counsellors should have formal education in mental health counselling and should take responsibility for conducting research into the effectiveness of integrated care.
In summary, family health teams are ideally supposed to engage in interprofessional collaborative care. The above review of the literature leads to questions as to whether this is actually happening, citing many challenges. While medical homes are a way of promoting an integrative or holistic health care assessment, there is lack of consensus if this is actually happening. Family physicians still need to remain a part of mental health care because they are an integral part of the team dynamic. Patients often trust their doctor's opinion and it is this trust that can translate to their willingness to access mental health services. The literature also stated there are various barriers to collaborative care.

**Primary Care Mental Health Counselling: A New Profession**

Counselling in primary care is a relatively new area of study. Within primary care teams, counsellors provide the majority of mental health care. Recent research has explored mental health providers’ roles as well as the effectiveness of the role on patient mental health in the field of counselling. Research has also identified challenges that exist for counsellors who are working within family health teams. Much as the Romanow Report leaves out mention of mental health care, reports on collaborative interprofessional mental health care in Canada do not include perspectives of mental health service providers such as mental health counsellors or social workers.

**Counselling: a new role in primary care.** The role of counsellors in Canada is very diverse (Gazzola & Smith, 2007). Many provinces have undergone the process of regulating the profession. For example, in 2007 the province of Ontario passed the Psychotherapy Act, which provided an amendment to the health professionals act (College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario, 2013). Although counselling within primary care is not regulated, many counsellors come from backgrounds that are included within the
regulated health professionals act (e.g. social workers and nurses) and counselling and psychotherapy is included within their scope of practice. The following section provides an overview of the research on counselling in primary care. This research has been organized into three themes: the role of counselling, its effectiveness, as well as challenges counsellors face in primary care settings, in the UK, the US and Canada.

**UK research**

*The counselling role.* Counsellors who choose to work in primary care settings face many pressures. One such pressure is redundancy. In one UK study, Eatock (2000) discussed the future of primary care and, more specifically, what role counselling will play in these settings. This author asserted that it is unclear whether counselling will remain a standalone part of the interprofessional team or if other healthcare professionals who consider counselling to be part of their practice will absorb the role. Will counselling remain a separate profession within the context of primary care or will it become, at least in part, “medicalized”? Eatock (2000) reported that this new role will “continue to offer a different perspective on health and healing and remain in place to further enrich the services offered in primary care” (p. 161).

There has also been research on levels of satisfaction with the counselling role in primary care settings. For instance, in an early qualitative study of physicians and counsellors regarding counselling services in primary care settings, UK researchers Sibbald, Addington-Hall, Brenneman, and Obe (1996) showed that both counsellors and physicians were satisfied with the service. They identified a range of benefits and few disadvantages. They explained that counsellors within primary care settings provide “formal sessions to patients in which patients are helped to define their problems and are enabled to reach their own solutions” (p.3). In interviews, the counsellors were asked to discuss characteristics of counsellors, their working arrangements,
their relationships with general practitioners, advantages and disadvantages of working in a primary healthcare setting, and goals and barriers to providing mental healthcare in this setting. Physicians were asked questions about characteristics of the counselling service, the process of introducing the service, patient referrals, communication with counsellors, service advantages and disadvantages, goals, barriers and proposed changes to service provision. Interestingly, this study focused on evaluating counselling services and thus did not question the practices of physicians who are in a leadership role.

In a British study of the role of mental health workers in primary care, England and Lester (2007) called for increased collaboration within the interdisciplinary team. This qualitative study of multiple team members' perspectives on mental health counselling in primary care pointed to the need for increased collaboration when discussing how to implement this new mental health counselling role. England and Lester (2007) argued that failure to plan for collaboration can create tensions among key stakeholders and they highlighted the importance of consulting with all stakeholders. England and Lester (2007) described both “top-down” and “bottom-up” approaches to implementation. Top-down theories suggested implementation comes from policy makers and/or administrators with the assumption that those at the bottom will carry out instructions without question. This approach may make people who are located at the bottom of the hierarchy feel undervalued and lacking in agency. In contrast, bottom-up approaches occurred when decision-making is left to the person providing the service (for example, the mental health worker). A bottom-up approach may lead workers to adopt responsibilities beyond their own capabilities. Neither of these approaches was ideal since both may cause tension with those who are not having a say in decision making, whether these people are located at the top or bottom of the hierarchy. England and Lester (2007) proposed a “horizontal method” which was defined as “policy implemented as a result of continuing interactions between a numbers of players who
negotiate until a consensus is achieved” (p. 211). Flat lined or horizontal systems are needed in order to ensure that all stakeholders' perspectives are being valued and taken into consideration.

In another British study, Ferrand (2007) acknowledged the impact of the new role of counselling on primary mental healthcare. This qualitative study employed semi-structured interviews of clients, GPs and managers/supervisors. Interestingly, Ferrand (2007) did not include mental health workers in the study. Results indicated that stakeholders were generally pleased with the provided counselling services.

Gilbert and Russell (2006) examined the experiences and role of the new mental health worker in a primary care setting. They explored mental health worker roles, types of therapies used, characteristics of clients and caseload, clinical supervision, personal effectiveness, professional development needs, relationships with other health professionals and the worker’s sense of identity. Gilbert and Russell (2006) examined the issue of role ambiguity and what potential workers could bring to mental health care in the future. As the mental health workers in this study had less formal education than the professional counsellors, they provided fewer counselling services and were seen as aids to the professional counsellors. Moreover, this position was considered to be a transitional step on the way to becoming a professional counsellor. The authors' program provided time-limited therapy; health promotion; community liaison and development; and information management. Mental health workers reported that they spent the greatest amount of time providing time-limited therapy such as Facilitated Self Help (FSH) and Brief Solution-Focused Therapy (BSFT). They expressed preference for the first approach because they considered it to be “lower intensity”. The study did not find any consistent pattern regarding types of clients serviced, which implies that the patient population was diverse. The professional development needs that were identified included additional training in BSFT and CBT. The study also looked at relationships with other professionals and the mental health
worker’s sense of identity. Mental health workers reported having to work hard at promoting their role and described feeling conflicted about their sense of identity as mental health workers.

**Effectiveness.** Effectiveness is often defined in terms of overall effectiveness and cost-effectiveness. In one recent British study, Bower, Knowles, Coventry, and Rowland (2011), outlined the high prevalence of mental health and psychosocial problems in primary care patient populations. Bower et al. (2011) identified counselling as a potential treatment for these patients. However, the authors noted that there is a lack of consensus over the effectiveness of this type of service in primary care. Bower et al. (2011) concluded that counselling is associated with significantly greater clinical effectiveness in addressing short-term mental health outcomes in comparison to usual care but provides no additional advantages in the long term. Moreover, while patients reported high levels of satisfaction with the services provided, these services did not reduce overall healthcare costs. In a British study, Brettle, Hill and Jenkins (2008) examined evidence from 26 studies with regards to clinical effectiveness, cost-effectiveness and user perspectives. Similar to Bower et al., (2011) they identified short-term benefits associated with mental health counselling in primary care and high levels of patient satisfaction.

A British study on the effectiveness of counselling services in primary care showed some modest yet significant evidence for non-directive approaches to counselling (Rowland et al., 2000). This study evaluated Randomized Control Trials (RCTs) of counsellors providing “non-directive” approaches or supportive counselling. Tentative evidence suggests that “counselling patients are more likely to be considered recovered than usual GP care patients” (Rowland et al., 2000, p. 215).

**Challenges.** In an article on counselling in primary care, Davidson (2000) addressed the challenges of this new role. In this British article, counselling in primary care is described as “facilitating change through the relationship between client and counsellor by providing optimum
conditions for learning, reframing or expression (p. 191)”. Effectiveness was linked to “the personal qualities of the counsellor, which are in turn effected by stress levels, job satisfaction and the level of perceived support for the process” (Davidson, 2000, p. 191). Davidson (2000) explored the need for financial constraint while also protecting the quality of services. Managers must prevent the exploitation of workers, facilitate ongoing professional development, and ensure safe and appropriate working conditions. Davidson (2000) also discussed the need to assemble a backup plan for crisis situations and special needs patients. Managers also needed to provide guidance regarding extraneous clinical activities such as when counsellors have court appearances. Counsellors needed to see themselves as part of an integrative mental health service. Both managers and counsellors should be involved in decision making about the way primary care will develop.

Research also highlighted the importance of community engagement with regards the provision of mental health services in primary care settings. Firth (2010) examined various barriers to the successful delivery of mental health services in Britain. Brevity of work is one barrier that was identified by Firth who suggests that sessions should not be “capped;” rather, counsellors should be able to judge on a case by case basis the amount of sessions a client needs. A brief model is another barrier; while brief models of counselling are helpful in certain situations, not all clients will benefit from the use of these models. Again, Firth stressed that counsellors need to be the judge of what models will best suit their clients. Lack of regulation and monitoring is a barrier that can be resolved by hiring those from regulated health professions or developing policies for regulation.

Recent changes in primary care have impacted how counsellors work. Foster (2000) provided a review of new structures for the provision of counselling services in Britain. Foster
not only explored how supervision of counselling practice is implemented, but also highlighted the need for this supervision and for regulating counselling practice through “clinical governance.” These setting changes have impacted counsellors negatively. For example, this article indicated that there is no set pay scale because the act of counselling is unregulated. Foster (2000) asserted that, “There are no agreed national pay scales, no standardized contracts of employment, no awareness of levels of training or standards of accreditation, and dangerously there is often no real understanding or agreement by decision-makers as to what ‘counselling’ is” (Foster, 2000, p. 180). Counsellors in primary care are facing the dilemma of wanting to change the system while trying to work within the system.

Mellor-Clark (2000) addressed the strengths and weaknesses of counselling in primary care as well as opportunities and threats (SWOT) to counselling in this setting. This review, in the form of a SWOT analysis, provided insight into the need for respect and recognition of the work that counsellors do in primary care settings. It also stressed the need for professionalism, training, and clear guidelines. For instance, this researched stated it is important to implement time-limited therapy, have appropriate wait-list management and liaise with the primary care team. It was also important to establish appropriate terms of employment such as best counselling practice and expectations of the counsellors’ role.

US research

The counselling role. Gersh (2008) documented the lived experiences of counsellors in primary care. This US doctoral dissertation also acknowledged that limited research has been done from the perspective of those providing mental health services and maintained that continued documentation of counsellor experiences is needed in order to gain a greater
understanding of how to better support those who provide these services. She discussed the importance of supporting counsellors when they are transitioning from counselling to counselling in primary care. The participants in her study identified various challenges, including working within the culture of the medical model and navigating differences within the team regarding approaches to patient care. Participants also discussed the impact on counselling skills when working within integrative settings, what changes need to be made when counselling in primary care, and what treatment approaches are used.

Adapting to the pace of patient care in primary care settings is a central challenge associated with providing counselling services within the medical system (Gersh 2008). Counsellors are expected to work at a quicker pace, spend less time with patients, and employ treatment interventions that are based on evidence-based practice. Furthermore, whereas medical providers often treated depression with medication, counsellors tended to use behavioral strategies. Gersh’s (2008) research study found that counsellors working in primary care settings tend to use more evidence-based approaches (for example cognitive behavioral therapy) rather than other counselling approaches.

**Challenges.** Preliminary research has also investigated self reflective practices of counsellors and in particular feelings of tension and inadequacy (Rizq, 2006; 2013). In her first study, counsellors were interviewed about their thoughts and feelings regarding working with clients who had borderline personality disorder (Rizq, 2013). Many of the participants described feeling a “sense of failure” while working in primary care. A phenomenological analysis of the interviews yielded three themes: recognition and implications; managing feelings of inadequacy; and managing dilemmas in a primary care context. The first theme of recognition and implications relates to the counsellor’s initial diagnosis of the client. Although the diagnostic
process was informal, the counsellors referred to the DSM-IV when describing the features of borderline personality disorder. The second theme of managing feelings of inadequacy referred to the counsellor’s ongoing countertransference with clients who felt takes up a great amount of energy and emotional space within the counselling session. The third theme of dilemmas in a primary care context related to the challenges that occur when working with this type of clientele within primary care where there is limited access to resources and the counsellor is met with the task of balancing the need for specialized client care with capacity for care.

In an earlier study of counsellors’ experiences, Riziq (2006) used reflective practice groups to analyze reasons for taking up a counselling position in a primary care setting; experiences of in-service training; experiences of client work; working within multidisciplinary teams; and future professional development. The sample examined new workers who had undergone training specifically to work in primary care. Workers reflected that they often felt rushed and pressured to “catch on.” They also questioned the credibility of their training as they had not received formal certification. Moreover, they felt that their role was often misrepresented.

**Canadian research**

*The counselling role*. Research has also explored the need for flexibility within the counselling role. For instance, in a Canadian study of the Hamilton Program, Kates (2008) found that counsellors who are working in primary care need to be willing to see clients with a wide variety of issues. While counsellors working in this setting are not expected to be experts in all areas, they must be skilled in recognizing when a referral is needed. Moreover, they are expected to provide care “in the style of the primary care provider” (p. 74). Kates introduced the concept of “the three worlds of primary care” The First World refers to daily program operations, the Second
World refers to the organizational framework, and the Third World refers to the financial environment.

**Effectiveness.** A Canadian article yielded similar findings on effectiveness (Wang & Patten, 2007). The researchers of this study examine perceived effectiveness rather than actual effectiveness. They stated that there is no apparent difference between perceived effectiveness among primary care physicians and mental health specialists. They define perceived effectiveness as how much the provider felt they contributed to the overall progress of patients.

**Challenges.** In a Canadian review, Kates, Crustolo, Farrar, and Nikolaou (2002) identified additional challenges for mental health counsellors who are working in primary care, including isolation as well as other practical issues such as finding adequate counselling space. This review described counselling in family health teams and discussed the background of counsellors as well as the types of problems they deal with on a daily basis. Data from a program evaluation of the Hamilton Family Health Team was used for the purposes of discussion. The review described what Kates et al. (2002) believed was a successful attempt at integrating counselling services into primary care. While they identified difficulties, they were eventually “resolved.” This review indicated that offering mental health counselling within primary care settings has increased the capacity for primary care to support people who are living with mental health struggles. Although various stakeholders who were surveyed were satisfied with the program, the study examined data from an evaluation of a program and does not survey the stakeholders independently from their workplace. The persons conducting this review are also in administrative roles within the setting which may impact the participants’ responses. They used data as reported by counsellors who reported statistics as part of their job requirement. They did not interview or survey
counsellors independently from this task, which could interfere with the reliability of the findings as participants could have felt pressured to answer positively.

The above section cites the literature on the role of counselling in primary care. While this role is somewhat new, there existed evidence of the effectiveness and challenges inherent to the role. While there were many positive characteristics of the role, there were also many challenges. It is also important to point out while there exists a great amount of research in the UK (with a few articles from the US) there is a lack of research that is Canadian-specific.

Summary

The above literature review demonstrated that there has been increased demand for mental health services in combination with increased recognition of mental illness among patients who receive care from primary healthcare providers. Many research studies indicated that there is a need for primary health care reform, with one solution being the creation of collaborative interprofessional health care and, more specifically, family health teams. Including mental health counsellors within family health teams may be a means of making mental health services more accessible. Mental health counsellors are employed from a variety of professional backgrounds and they provide treatment for various mental illnesses and support to people who are living with these illnesses. It is apparent from this review that more research on the experiences of counsellors in this new role is needed. This study addressed this need by interviewing those who provide mental health services with family health team settings.

The above literature review uncovered several issues regarding the topic of mental health counselling in primary collaborative interprofessional healthcare settings or, what in Canada are referred to as, family health teams. Mental health and mental illness are areas of great concern across Canada and in particular the Ontario government is taking the increasing incidence and
prevalence of illness as well as the increase in demand of services very seriously through the creation of family health teams and the mental health counselling support role.

Healthcare reform in Canada has called on primary health care practitioners to be leaders in providing mental health care since many persons initially seek out services within this setting. Moreover, locating services within this setting may help to increase quality of care. It may also help deal with gaps in services such as the limited number of psychiatrists and may prevent hospitalization by putting the focus on patient empowerment.

Additionally, the research review discussed how primary care settings are changing due to the creation of family health teams who provide care within an interprofessional collaborative context. While much is written about the need for collaborative care, there exists a lack of information on what collaborative care actually looks like and how to conduct it within the context of mental health care provision.

While mental health counselling has been viewed as an essential part of mental health care, there exist many challenges to counselling in this new setting. Mental health counselling in family health teams is a relatively new role with limited research documenting what counselling is from the perspectives of counsellors themselves. This research adds to the research on experiences of counsellors providing this service. Much is written from the point of view of psychiatrists and physicians and/or administrators and policy makers. Although there has been some research from both the UK and the US from the point of view of counsellors, there has been little Canadian-specific research from the point of view of mental health counsellors who are working in family health teams.

The literature also revealed a lack of clarity and consistency regarding the definition of counselling and, more specifically, what role counselling services can play in providing mental health care within family health team settings. This research project added to the existing
literature by exploring how mental health counsellors in Ontario come to understand and define their counselling role within the family health team. Given all the issues that are cited in the above review of the literature it would be essential to know the experiences of those providing mental health care services in family health teams to understand how best to inform best counselling practices. The next chapter discusses the methodology of the research.
Chapter Three: Methodology

The following chapter provides an overview of the methodological approach used in this study. Mental health services are widely regarded as a necessary component of the primary care model. Counsellors are often seen as effective service providers within this model. Primary care physicians are sometimes appreciative of counsellors’ expertise as are the consumers of mental health services. Family health teams provide a venue in which professionals from a variety of backgrounds can work together in order to promote mental health and treat mental illness. Mental health counselling is a new role within this model. While research has been conducted within both the US and the UK on the counselling role in primary care, more research is needed from a Canadian context. This dissertation addresses this gap in the existing research and explores intersections of mental health counselling within the specific setting of primary care and family health teams in Ontario. The research question is: How do the experiences of mental health counsellors working in family health teams help inform counselling practice? And how can understanding these experiences create a comprehensive understanding of mental health counselling within a family health team context?

Furthermore, those who provide counselling services (counsellors, social workers, nurses, etc.) need the opportunity to voice their experiences of working within this new model. Listening to the stories of counsellors can help improve counselling practice and collaboration within family health teams. By providing counsellors the opportunity to tell their stories about mental health counselling, this research project provides insight into the facilitators and barriers of working within the role and the processes by which counsellors participate in collaborative mental health care. The focus of this research will be on mental health counsellors who are working within southern Ontario family health teams. This area has the largest network of Family
health teams per capita in North America (Government of Ontario, 2012) which made this an ideal location for the research study.

Conceptual framework

The conceptual framework for this research is social constructivism. Social constructivism holds the notion that individuals create knowledge through the way they perceive themselves in the world. This theory was derived from Vygotsky (1978), a cognitive psychologist who rejected the notion that one could objectively separate learning from one’s social context (Kim, 2001). Social constructivism is based on certain assumptions. These assumptions are about reality, knowledge and learning (Kim, 2001). Social constructivists believe that reality is constructed by one’s social experiences. A social context is needed in order for reality to happen. Reality cannot exist without a person’s perceptions of how they fit in the world. In order for knowledge to be generated, it needs to be created through one’s appraisal of social interactions. Individuals create meaning through their interactions with one another. Moreover, learning is an active process. People are not buckets to be filled with information; rather, they need to interact with information and relate to it in a meaningful way. This learning occurs through social interaction.

The concept of intersubjectivity is also a part of social constructivism (Kim, 2001). Intersubjectivity refers to a shared understanding of the world among certain groups of individuals who have common interests. For the purposes of this research, those who provide counselling within a primary care context are considered one such group.

The process of counselling is a social phenomenon, as is working within teams. Counsellors’ understandings of counselling are derived from their interaction with their clients and colleagues. They construct knowledge about their workplace through relating to people
within it. For the purposes of this study, knowledge is constructed through the process of telling stories about counselling within family health teams.

**Qualitative Approach**

Qualitative research plays an increasingly important role in healthcare research. For example, Sandelowski (2004) maintained that qualitative research extends beyond what quantitative research can provide by placing importance on practical knowledge. She stated that “knowledge in practice disciplines entails not just knowing that but knowing how, why, whether or for whom” (p. 1367). Sandelowski (2004) stressed the importance of knowledge that is generated from direct human experience. This type of knowledge can serve as a basis for later evidence-based research.

Healthcare communities have not always responded well to qualitative research due to an emphasis on evidenced based outcome research such as random controlled trials. For example, Hoff (2011) wrote that over the years qualitative healthcare research has been on the decline. In his position paper he argued for a renewed interest in qualitative research not just as an alternative but also as an accompaniment to other quantitative methods. He maintained that “many of our deepest understandings of how health care works derive in meaningful part from qualitative research studies” (Hoff (2011), p. 54).

This research focused on qualitative interviews with counsellors who practice within southern Ontario family health team. This research explored the stories counsellors share about their experience of counselling within this new primary care model and how interprofessional collaboration impacts the counselling role.

**Narrative inquiry.** The narrative inquiry model was the primary methodology for this study. Given that counselling and interprofessional collaborative care practice are seen as social
processes (i.e. interactions between people) a social constructivist theoretical approach and subsequently a narrative inquiry method was considered by the researcher to be a good research method.

Narrative inquiry “begins in the experiences expressed in lived and told stories” and is “both a method and phenomena of study” (Pinnegar & Daynes, 2007, p. 5). Narrative models and qualitative research have been used in health care research because they provide insight into the lived experience of counsellors by providing in depth examinations of experience (Century, Leavy & Payne, 2007). Furthermore, the impact of the role of mental health counsellors has been studied using qualitative methods (Farrand, Duncan & Byng, 2007). Narrative methods have been widely criticized as being similar to other methods such as phenomenological or ethnographic research methods. While the researcher acknowledges this argument the rationale for using narrative inquiry versus other qualitative methods is due to an interest in examining participants’ stories.

This research is modeled on two studies that were conducted on the experiences of counsellors in primary care; one qualitative US study on the experiences of counsellors working within integrative teams (Gersh, 2008) and one British study on mental health workers in primary care (Gilbert & Russell, 2006). This research project differs by using narrative inquiry as the type of qualitative approach and by the location of the research (Ontario, Canada).

Narrative research developed out of social constructivist theory, and thus this approach is complementary to the social constructivist conceptual framework this study employs. By meeting with counsellors in primary care settings, the researcher has had the opportunity to hear many stories. The goal of this research study was to provide a more formalized process to glean the experiences of counsellors working within primary care and to get a sense of the essence of
counselling in this new setting (i.e. what it is really like). It was intended that counsellors recruited in this study had extensive knowledge about counselling and that they could articulate what they do within a family health team setting.

Moreover, the current study assumed that in order to access this knowledge one must also be a stakeholder within the setting. In this case the researcher is also a mental health counsellor who has been working within a primary care setting and has 15 years of counselling experience. Hollingsworth and Dybdhal (2007) wrote about the importance of extensive relationships. They differentiated narrative inquiry from other methods such as ethnography since the former requires the researcher to have a relationship with respondents. In this case the relationship is that the researcher also holds a similar professional role as her participants. They indicated that, when it comes to narrative inquiry, “the relationship between the researcher and participants is a primary influence on the study design...and the researcher’s perspective is based on the relationship between the knower and the known” (Hollingsworth & Dybdhal, 2007, p. 156). The research becomes participative.

Clandinin and Connelly (2000) also maintained that the way researchers conduct themselves in the interview will impact the shape of the participants’ narrative. Conditions such as time of day, formality of the interviewer, and level of inequality of power between interviewer and interviewee will influence the outcome of the interview. The goal of the interviewer/researcher is to establish a high level of rapport with the participant. In the context of this research project, the researcher being a counsellor who has experience working in primary care may have enhanced the interviewer/interviewee relationship. Furthermore, it was the goal of the interviewer/researcher to model and encourage an environment where interviewees felt comfortable to share information about work-related experiences. While the focus of the interview was on the participants’ stories the researcher tried to foster rapport through disclosing
her own professional work stories. Disclosure occurred when prompted by participants. For example when asked about practice locations, the researcher described how she was co-located within both of her practices but that one practice was within the office and another was above the office. Also when participants spoke of challenges, the research also responded that she had experienced challenges. The researcher took care to use the approach of letting the interviewee guide the process. Also the researcher did not self disclose unless prompted by the participant. Self disclosure only occurred when it would enhance the professional discussion.

Narrative methods have also been valued in health care research and practice. Rita Charon (2001), a pioneer in the field of narrative medicine, asserted that effective medical practice requires narrative competence. She maintained that it is essential for medical professionals to gather health information through carefully listening to patient stories. She described four narrative situations within the context of medical care: physician and patient, physician and self, physician and colleagues, and physician and society. She concluded that narrative competence promotes a greater understanding of patients and fosters connections that may bridge hierarchical divides.

Narrative methods have also been employed in counselling and psychotherapy practice. Narrative therapy, for example, stresses the importance of storying and re-storying as a means of making sense of the world (Ivey, D'Andrea & Ivey, 2012). Through this process, the story becomes just a story and not related to the identity of the individual. The goal of narrative therapy is thus to shift the story away from identity so that it becomes clear that the person is not the problem; rather, the problem is the problem and it is separate from the person’s identity (White & Epston, 1990).
**Research Process**

**Researcher position.** For this study, the researcher has taken a collaborative role in the research process. This was achieved through regular participant feedback. This is consistent with narrative methodology as it is considered participatory. The researcher is personally and professionally invested in the research project since it provided an opportunity for professional development. This study built upon the researcher’s previous professional development within the realm of mental health counselling, including clinical supervision by a psychologist; peer support and peer supervision in a group setting; and the development of a student practicum site within her family health team setting.

The researcher has been employed by a family health team in southern Ontario, in two different practice locations. Duties included the provision of counselling and psychotherapy services to patients of the co-located practices. There is no fee for this service as funding is provided by the Ontario Ministry of Health and Long Term Care. These funds are redirected through a transition agency called the Family Health Team Organization.

The researcher has held this position for five years and during this time has had many conversations about the nature of the work with other family health team members and also with other counselling professionals. During this time she has also read many academic and non-academic publications about family health teams and prior to conducting the research believed these publications to be quite idealistic. While some general challenges have been documented, there existed limited research on the experiences of those who live these challenges. The researcher has experienced various challenges over the years working in family health teams and over time it became apparent that she should focus her doctoral dissertation on stories of
counselling in primary care in the hope of documenting experiences. The researcher took great care to acknowledge and process prior biases and beliefs through supervision and ongoing professional reflection before conducting participant interviews.

Policy writers, researchers, and practitioners alike shared high hopes for the integration of mental health services within primary care settings. However, with change often comes tension and resistance. The quantitative research describing evidence and effectiveness of this approach, although necessary, does not provide insight into the nuances of the phenomenon. The researcher is interested in knowing what the stories counsellors tell have to say about counselling within interprofessional mental health teams not just to enhance academic knowledge but also to gain greater insight as to how to improve and strengthen practice.

Qualitative research provided detail about experiences and insight into how individuals “make sense of their lives” (Bogdan & Bilken, 2007) The process of interviewing counsellors to discover more information about their experiences working within a primary care context was part of a larger exercise in peer networking and professional support and mentorship.

Clandinin and Connelly (2000) explained that “narrative inquiries are always strongly autobiographical” (p.121). They indicate that narrative inquiry research interests come from stories of experiences from within the field. They placed emphasis on the fact that not only are stories personal; they also hold a broader social significance. In order for narrative inquiry to be successful, the research needs to provide insight into the larger social implication of personal experience. The researcher has chosen to collaborate with other mental health counsellors in order to understand professional experiences of counselling in the field; in turn, this resulting research project aided in constructing a larger narrative of counselling within family health teams in Ontario.
Research participants. Participants were mental health counsellors who work within primary care settings. They had received formal training in counselling approaches, either through completing a Master’s degree in counselling or another specialization (e.g. Nursing, Social Work, Marriage and Family Therapy), and had at least three years of work experience within a general counselling setting, not necessarily a Family Health Team. This requirement ensured sampling from a wide variety of professional backgrounds in counselling. At the time of the study, a broad sample was used so as to not specifically focus on issues from particular groups such as nurses, social workers, and marriage and family therapists.

Potential participants were contacted via email (See Appendix B) and information was shared about the study also through word of mouth (see Appendix C). Recruitment, which occurred over the course of six months, yielded seven participants.

Procedures. The following section describes each phase of the research process, including preliminary steps, conducting of interviews, and analysis of data.

Preliminary phase. The research process began informally when the researcher started to practice mental health care within a family health team setting. Since January 2013, a field journal and field notes were also written to document the research.

In 2011, the researcher began discussing ideas about research in family health teams with her employer. While supportive of the research, her employer wanted to give input as to potential areas of investigation. It was somewhat problematic as the researcher struggled to conceptualize a suitable research question. Colleagues expressed interest in the research during peer meetings and the researcher’s union has also been supportive. As recruitment was not from the researcher's own family health team, it was important to gain acceptance from the larger community that the research topic was an area of interest and that the researcher would be a suitable candidate to give
voice to counsellors’ experiences. This acceptance was gained through introductions from the researcher’s manager in combination with networking with colleague from previous workplace settings.

Upon approval from the Research Ethics Board of the University of Toronto, the researcher’s manager, who had agreed to help with recruitment, made contact with potential leads. The screening process was guided by participants’ suitability as previously defined as well as their interest in the project, willingness to share information, and ability to provide informed written and verbal consent. Their commitment to a semi-structured interview of approximately 1-2 hours was also necessary as well as being available for follow-up to go over transcripts and story maps, add additional information, correct any errors or delete any information they were not willing to share for purposes of the research. Previous professional experience had yielded some challenging experiences and through consultation with other professionals the researcher hypothesized that some stories might be too difficult to talk about. It was then the goal of the researcher to ensure confidentiality and anonymity and this was the rationale for not interviewing participants from her own family health team setting.

**Phase 1: recruitment.** Participants from various family health teams across southern Ontario were recruited. As previously stated, it was decided not to recruit from the researcher's own place of employment so as not to create any conflict of interest. Moreover, this decision helped to ensure anonymity since no one from her agency will be identifiable within the context of the research. Participants were recruited from different family health teams in order to maintain the research focus on the general nature of counselling and family health teams, not organizational issues from one particular setting. Sampling from a variety of agencies meant that when organizational issues were discussed by participants they pointed to broader systemic issues
rather than particular organizational climates. Recruitment was done mainly via emails that were sent to various mental health counselling program managers and practice leads across the region.

**In-depth individual interviews.** After screening, the researcher arranged to meet with participants at an agreed upon location. Research questions were adapted from Gersh’s (2008) qualitative study; they included,

- How did you come to work as a mental health counsellor (social worker, nurse, therapist, counsellor) in a family health team?
- How do you approach clients/patients at an initial visit?
- How do you work with clients with mental illness, psychosocial issues or life issues?
- Can you tell me about a time when you felt positively about your work? Can you tell me about a time when you felt negatively about your work?
- How do you work with people from other professions within the team? Can you tell me more about what you do?
- What are your hopes and fears about working in this setting in the future?

Each individual participated in a one to two hour semi-structured interview. The interview commenced by the researcher going over the consent form and offering to answer any additional questions the participant may have about the interview. An honorarium was offered in the form of a ten dollar gift card to a nearby coffee shop and an explanation was given that it was theirs to keep even if they chose not to continue with the study. The researcher confirmed that the participant had previously received the list of potential questions, that they were willing to answer the questions on the sample interview guide and that they consented to the interview being audio-recorded. After receiving consent and answering any questions, the researcher turned on the digital voice recorder. At the conclusion of the interview, the researcher made plans to contact the
participant again to share the transcription of the interview and confirm that they felt comfortable sharing the transcribed information.

**Phase 2: preliminary analysis and second meeting.** The analysis process included transcription of the interview, chunking the interview into segments, coding the interview segments, creating a story map, and identifying core message and themes.

The analysis phase began by transcribing each interview word for word, including inflections such as hmmm or uhhhh, pauses, laughter and any other significant behaviour. By doing so, the researcher hoped to preserve the richness of the interview as much as possible. However, in the examples below, the researcher has, at times, removed these inflections in order to increase the readability of quotes from the interview. Once the interviews were transcribed, they were reviewed once more and any necessary corrections to the transcript were made. The researcher also went through the transcriptions, checking to ensure that names, places and any identifiers were deleted. The researcher chose to use an XXX marking where deletions were made.

Secondly, each transcript was chunked into smaller segments that are referred to as data units. This was done purely for organizational purposes and would later serve to aid in cross referencing within and between transcripts. Each unit of data consisted of approximately 15-20 lines of text with an attempt made to chunk whole paragraphs together. See Figure 1 for an example.
### Figure 1: Example of Data Unit

<table>
<thead>
<tr>
<th>Data Unit #</th>
<th>Interview Transcript</th>
<th>Corresponding Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Pauline - So you’re interested in getting more information together to give to others about “how to” in certain situations? PX17 - Yeah and I think that we would all benefit from that knowledge, right? [Professional role: need for definition] Pauline - Yes PX17 - I’m mostly interested in terms of the impact on patients because I think that’s what…and there’s a lot of organizational issues [Healthcare system: issues] that impact the organization of mental health so that there’s no leads…so that the ED who has no clinical background [interprofessional collaboration: challenges] who then sort of says something or else it’s up to the poor social worker who has no time to create these structures right [professional role: burdening]? Pauline - Right</td>
<td>Professional background(need for definition) Healthcare system (issues) Interprofessional collaboration (challenges) Professional Background(burdening)</td>
</tr>
</tbody>
</table>

A third step involved coding the interview data. Coding is described as “a progressive process of sorting and defining and defining and sorting those scraps of collected data…that are applicable to your research purpose” (Glesne, 1998, p.152). Within the transcript, codes were assigned by labeling certain portions of the text with one or two words. This was an inductive process and often participants’ language use served as labels for codes. Major codes (Glesne,
1998) were assigned to sentences which represented various concepts or central ideas. For example, in the above figure (Figure 1) the major code of “professional background” was assigned to the following text by Participant 1: “Yeah and I think we would all benefit from that knowledge [Professional background: need for definition]” In this quote, “professional background” represents a major concept that the participant was discussing and the subcode, or subtopic related to the concept of professional background, was the “need for definition” of the professional role. Once the initial coding was completed, the researcher re-read the transcript and reviewed each code that had been derived to ensure that she had captured the correct meaning of each participant’s narrative. This method of analysis was used for all seven interviews.

Following the analysis of data, the next step was to transfer the descriptive codes onto what Richmond (2002) refers to as a story map. A story map is a map of overlapping concepts that are derived from the questions and from the interviews that are then paired with a time orientation (past, present, or future). This map allows both the researcher and the participant a view of the shared narrative and induced meanings. This research tool, which was adapted from Richmond (2002), works to keep participants’ narratives in a form that allows for further conceptualization. In its essence, the story map affords the opportunity for both researcher and participant to reconstruct participants’ stories by examining the larger narrative.

It was anticipated that participant narratives would be organized under the headings of “Professional Background,” “Working with Patients/Clients,” “Interprofessional Collaboration” and the “Healthcare System.” These headings were developed from the researcher’s prior understanding of the role and complemented initial findings in the data. These headings were placed on the horizontal axis of the story map. The vertical axis listed the headings “Past,” “Present” and “Future.” Stewart (2007) recommends orienting the story in this manner; she
maintains that temporal organization of a story makes it meaningful. Moreover, since participants reported having many years of counselling experience it was anticipated that their stories would take place over time.

From the main story map (see Figure 2), the researcher created a story map for each participant by transferring their respective descriptive codes in line with the structural headings and time orientation. Next, the researcher reviewed the participants’ interview transcripts and descriptive codes a final time, revising and refining their respective story maps to ensure thoroughness.

Figure 2: Main Story Map

<table>
<thead>
<tr>
<th></th>
<th>Professional Background</th>
<th>Working with Patients/Clients</th>
<th>Working with Others (Interprofessional Collaboration)</th>
<th>Healthcare System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past Experiences</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present Experiences</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future Intentions</td>
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</table>

The final step in this phase was to examine each story map and identify any core messages or themes that became obvious from the main points. The main idea discussed in the interview became the core message. Additional subthemes were also identified.

Second meeting. The story map, main message, accompanying themes and preliminary findings were shown to each participant during this phase of the research process. All interviews
were personally transcribed by the researcher and each participant read and verified the validity of the transcription. Each participant also had the opportunity to omit any information and comment on any potential identifiers for deletion. Due to the large geographical area covered and time constraints, the researcher offered to connect via telephone as well as email for the second meeting. The researcher was also available to meet in person for a second meeting but she wanted to give participants other options that may better suit their schedule. The researcher also repeatedly communicated to participants that she was available via telephone and email throughout the study.

During the second meeting, participants were asked to keep in mind the following questions:

1. Does the story map illustrate your views?
2. What is missing from your story map? Is there any information you would like to add?
3. Do you have anything else to say about your story map?

During the second interview the researcher took notes on any additional information and any changes that needed to be made. Any additional insights gained from the second meeting were noted. After each interview the researcher wrote additional field notes on how the interview went.

**Phase 3: final analysis and writing.** In this phase the researcher solidified themes for the story maps and constructed a narrative profile. She also incorporated feedback from the second meeting with participants. Writing of the dissertation was completed and a copy of the revised draft submitted to her committee for their review before setting a defense date.

**Phase 4: final results and dissemination.** All participants will be given a final copy of the study. Results will also be given to the researcher’s family health team, provincial associations and any other interested stakeholders after successfully completing her doctoral defense.
Summary

The above chapter illustrated the research method of inquiry. It outlined the process by which interviews took place and the method of analysis employed. The following chapter will provide within participant results.
Chapter Four: Within-Participant Results

This chapter details the within-participant results. For each participant, this chapter provides a brief character sketch; a description of the first interview and initial story map with corresponding core message and themes; a brief discussion of the second interview; and the final story map, core message and interview themes. The character sketch includes details about the participants’ professional development, years of counselling practice and other pertinent information. The core message represents a dominant theme or idea derived from the participant interview. Participants are listed in the same order in which they were interviewed.

Participant X17

Character sketch. Participant X17 was recruited through email. At the time of the initial interview, she identified as a social worker with 30 years of experience and a background in trauma counselling. She had worked in multiple settings on both the front line and in hospital. At the time of the initial interview, she was practicing in a family health team as a social worker and had been the practice lead for the past year and a half. She explained that her “clinical work” included case management and psychotherapy. She saw clients/patients for both short-term consultations and long term therapy. She described her client/patient roster as diverse and complex. In addition to working as a counsellor, she described participating in the delivery of supervision groups. At the initial meeting, Participant X17 described her interest in having more information on mental health services in family health teams.

First interview. This interview marked the first occasion the researcher had met with a counsellor outside of her own family health team. The interview took place within a very large urban centre, in a busy office environment; consequently, the meeting started later than expected.
Participant X17 was enthusiastic and knowledgeable about her role as social worker and practice lead. This was conveyed through her warm tone and her welcoming stance. She was positive throughout the interview and it was evident that she cared very much about her work and also valued her professional relationship with members of the family health team. It was also evident that she worked very hard and did not have much free time during her workday. The meeting lasted 90 minutes and she stayed after office hours in order to complete the interview. She helped me with recruitment by giving me contact information for other potential research participants. She also gave me information regarding a future conference and the provincial association. This conference was on mental health in family health teams and the association she refers to is the Association of Family Health Teams of Ontario. The conference was later cancelled for unknown reasons.

Upon completion of the story map (see Figure 3) a core message and two themes from the interview were assigned. The initial core message for Participant X17 was “Importance of interprofessional relationships.” The themes were: “We are working hard” and “We are doing a lot.”

**Feedback from second meeting and final story map.** The researcher met with Participant X17 for a second time via telephone. The meeting lasted approximately one hour. Prior to the meeting, a copy of her initial story map and coded interview was sent to her for review. In this second meeting, the researcher provided an explanation of the analysis and coding. Participant X17 was asked the following questions: does this story map adequately display your views? Is there anything missing from this story map? Is there anything else you would like to add about your experiences?
When examining each portion of the story map, Participant X17 added some additional information. While reflecting on the column “Professional Background,” she added that she had submitted a proposal for counsellor supervision within her workplace setting. This was added under future intentions as it was something that she hoped would happen in the future. When asked if there was anything she wished to add under “Working with Patients/Clients,” she indicated that her intention is to continue to offer strength-based services in alignment with best practices as indicated by the College of Social Workers of Ontario, the college to which she belongs. These two points were added to the “Future Intentions” row under the “Working with Patients/Clients” column. She also stated that she has found that there has been a lack of services for complex trauma within her community, and that her impression of the current funding model is that it does not afford doctors the ability to provide mental health services for complex trauma. These points were added under the column labeled “Health Care System”. All changes are underlined in the final version of Participant X17’s story map (Figure 4). The researcher also presented Participant X17 with an initial impression of her core message and subsequent themes of the narrative. The core message was that “Relationships are important” and themes were “We are doing it all” and “We are doing a lot.” While these two themes are similar they indicate the breadth of scope of practice in combination with the high volume of referrals. Participant X17 appeared very interested in how her narrative had been understood and wanted to ensure that she conveyed the true meaning of her experience.

The final core message and themes were discussed at length. Participant X17 wished to change the language of the headings and elaborate further on the meaning of each heading. For example, the core message that was presented was that relationships are important. Participant X17 further articulated that the type of relationship is important and that, in her professional
experience, relationships that have high collaboration are important. When discussing the theme of “We are doing it all” she felt that this was not always the best practice. She felt that she and her colleagues needed to prioritize services, meaning they would need to discuss what services they could provide and what services would be better served by other agencies or counselling settings. She explained that she took on a great deal of responsibility within the team. She also reiterated that she felt reassured when, at a team meeting, it was stated that mental health had been made a priority over the next five years. The theme of “We are doing a lot” was also discussed. Participant X17 outlined the pressure and stress that resulted from the high volume of referrals she received from her family health team and the diverse array of issues her patients/clients present with. At the end of the second meeting, Participant X17 again expressed enthusiasm for the research and wanted to be updated once it was finished. Her sentiments allude to the importance of the research.

Final core message and themes. The final core message and themes changed as a result of the second meeting. The final core message was changed to “Importance of high collaborative relationships.” The themes were changed to “Needing to prioritize” and “Impact from high volume of referrals.” Table 1 provides a synopsis of the final core message and themes.

<table>
<thead>
<tr>
<th>Table 1</th>
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<tbody>
<tr>
<td><strong>Participant X17</strong></td>
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<tr>
<td><strong>Final core message:</strong> Importance of high collaborative relationships</td>
</tr>
<tr>
<td>- Witnessing past challenges has illustrated the importance of teamwork</td>
</tr>
<tr>
<td>- Present working conditions are enjoyable (high rapport with colleagues)</td>
</tr>
<tr>
<td>- Other settings (i.e. hospital settings) are not as collaborative</td>
</tr>
<tr>
<td>- High collaborative relationships facilitate patient care</td>
</tr>
<tr>
<td><strong>Theme 1: needing to prioritize</strong></td>
</tr>
</tbody>
</table>

62
• We are doing it all (many different counselling services offered)
• Need for greater independence on scope of practice
• Generalist approach used (see patients/clients with diverse presenting issues)
• Complex cases
• Needing to better define where counselling service priorities lie

Theme 2: impact from high volume of referrals

• Very busy
• Long wait list for non-urgent referrals
• Feels as if constantly “lagging behind”
• Funding model does not take into account the need to treat urgent or complex patients

**Importance of collaborative relationships.** Participant X17 discussed the importance of collaborative relationships repeatedly during the interview. For instance, at the beginning she described her decision to work in a family health team by noting:

> I chose this place because it had very amenable bosses… it was very important to me because… when I worked at the hospital we always had social workers from their family health team come to our supervision meetings… they felt so alienated within their own family health team so we allowed them peer supervision with us… So I was very cautious that within a family health team there is a great possibility that you have horrible relationships and poor collaboration and all those things… I wanted to have doctors and EDs [Executive Directors] who were respectful of social work and of the collaborative process (PX17, p.6).

In the interview, Participant X17 described her family health team as an ideal place to work. However, she had heard stories that gave the impression that some team members may not be appreciative of the role that mental health counsellors play in the family health team. Others have
told her about challenges that exist with the collaborative process and the isolation they have felt when working within a team setting. She decided to take the family health team position because it was conveniently located close to her home and she felt a high level of rapport with her colleagues and the administration. She identified the latter as the most important factor in her decision to work in a family health team. Reflecting on the difference between working in a primary care setting and working in a hospital, Participant X17 explained that, in her experience, the former

is much more collaborative…in a sense…I mean, I may have been a part of a mental health department in a hospital but it was extremely un-collaborative…The accessibility was not there in terms of…the psychiatrists and whoever…In this [primary care] environment we are in contact with a doctor…the doctors and nurses and the dieticians and the pharmacists…all the time so that on each case there is much more pickup in terms of everybody working together (PX17, p.8).

Participant X17 explained the function of a family health team and how, in her experience, everyone works together to help support the patient. She described this setting as being more collaborative than the hospital in which she previously worked since, in the latter setting, mental health was delegated to her department.

Participant X17 also explained that her family health team appreciates the role played by mental health service providers and has afforded her the opportunity to make clinical decisions. She outlined ways that she manages her caseload and waiting list, and explained that she does not feel compelled to prematurely end the professional relationship with clients/patients. She explains her team’s case management style:
3 or 4 times a month…someone skips the [waiting] list…If a person we are having an intake with is a child or adolescent then we would prioritize as in-person assessment and services if that’s appropriate…We would also prioritize for post-partum depression…in terms of skipping the waiting list. So we have possibilities of skipping it but otherwise we set them up within seven months for individual [counselling]…Crazy…you know…I say, “you need more social workers” [laughing]. Or some people would argue less number of sessions but we actually don’t get that because I think our practitioners…we work with them actively enough that they appreciate that we are providing a solid service…that it is helpful in the long run and it is worth it to patients (PX17, p.11).

In the interview, Participant X17 described the challenges of working with a high volume caseload. She felt that there are certain pressures experienced by mental health service providers to work quickly and terminate relationships with patients in a timely manner so as to be cost effective. However, she felt that high collaborative relationships afforded her the opportunity to work longer term with patients who have complex needs. She explained that her family health team values her work and are appreciative of the “solid service” that is provided by the social workers in the practice.

She also described how her team is collaborating on a regular basis with regards to mental health care:

One of the things we do is we have the mental health psychiatry meeting once a week…That’s our meeting to talk about how to do things as a mental health team…any IHP [Integrated Health Provider] or primary care person can call that week and get a time slot usually for a half an hour and come and consult about a particular case (PX17, p.13).
She also outlined the types of mental health cases that are brought to the team during the mental health psychiatry meetings:

We have three types of cases...for this meeting...one is if there is somebody who has been recently discharged from the ER [emergency room] or from psych [inpatient psychiatry]or from addictions and we feel like we need to consolidate medication questions and resources…The second case is a client who is “borderlinish” but has exhausted everybody and their whole team...who is medication seeking...who is difficult...so they[the team members] just need to come in and have a discussion…We sort of guide them, usually around boundaries and good practices with these particular kind of clients…The third type of thing that people come to the meeting for is, “I don’t know what to do with this kind of patient. Help me.” (PX17, p.14)

Participant X17’s team also met regularly to discuss overall patient health and they had structured collaborative processes in place. At this point in the conversation, the researcher reflected back to her the impression that it appeared as if her team is one in which everyone has a well-defined role; everybody on the team knows each other’s professional role and where their responsibilities lie. She responded:

I’d say so…We also have as a family health team a number of practices which facilitate that…We have two things…We have a complex care clinic which happens…now it’s less frequent but I’ll say it’s every six weeks…X doctors and x nurse practitioners and the nurses and the pharmacists and the social workers and everybody come in together all in one meeting and we have two patients…The doctor or whoever has chosen the patients and each…of those two patients gets two hours and they are in an exam room and they are
being videotaped... The doctor comes and presents the case and... some particular questions and then we are all sitting there in this room talking about the case... and we choose three different professions who, in turn, go in to interview the patient in front of everybody else (PX17, p.15).

It is interesting to note the high level of collaboration that Participant X17 described and her enthusiasm for providing mental health care in this way. This situation appeared to be ideal and could be drawn upon for further detail on how best to practice collaborative care. Throughout the conversation she described how important collaborative care is to the client/patient and also to her team. She reported job satisfaction because of the high level of rapport she has built with her colleagues in the family health team.

**We are doing it all and needing to prioritize.** Participant X17 described the diverse mental health services her team provides. She discussed the types of clients she sees as well as her approaches to client/patient care:

There’s a big difference... in terms of the actual work... I mean for sure it’s a broader base of issues that you are faced with... I would say the majority of the work is short term... twelve sessions or under but I would say about 20% (which is higher than I thought) would be the chronic case management... You know, the story within primary care is that the primary issues are anxiety and depression... What we have noted very clearly is that it is anxiety, trauma, and then depression...(PX17, p.9).

Participant X17 discussed the difference between her present work in a family health team and her past work in a hospital. She explained that she has greater independence over her practice in the family health team and that she can be flexible with how she works with patients. She
asserted that in hospital settings she was mandated to provide service within a brief model and complex cases were not taken into consideration. Within her current role in the family health team she delineated between short term counselling and longer term case management. When asked to clarify what she meant by more complex cases, she explained:

> It’s like you are holding them and providing them with a safe environment so they can come back to you to deal with things as they come up...so...20%...[is] complex mental health...And we have those who have had a very longstanding kind of problem...so chronic...You have anxiety or the depression that isn’t first episode, that it is very chronic but also [people] who are ready to work... (PX17, p.9).

After a lengthy explication of different types of mental health services that are provided in her practice, Participant X17 explained that she often has a hard time keeping up with the high volume of patients/clients. The researcher’s goal was to normalize this difficulty since it was apparent she was doing a lot in terms of providing mental health care. The question that came from her feeling was, “how do you do it all?”. Her response was emphatic:

> Totally! And that’s a big question for us...‘how to’...I mean we have an annual day-long retreat for the social workers so we talk about whatever plans...And, you know, our big question this year is definitely going to be ‘what do we give up? (PX17, p.23).

Participant X17 was faced with the decision of what to make a priority and where to draw the line.

**High volume of referrals.** The final theme from the interview was that of the demand for service and the high volume of referrals. Participant X17 explained that her team is very busy. This was apparent as the office appeared to be very fast paced. Moreover, the appointment started
late and Participant X17 appeared hurried and apologetic. The researcher immediately empathized since this reflected her experience within her practice setting.

At one point in the interview she discussed how she handled the high volume of referrals, noting:

We have a single session drop in clinic once a week…no appointment or referral...just show up...but it’s only one session...and you work through whatever...Then, if you want to access any of the services, you would…be booked for an intake which is a telephone call…with the intake worker…We guarantee that you have an intake within three weeks (it’s usually one to two weeks) over the phone so that’s usually a 45 minute call so it’s a fairly extensive call with an assessment...There’s a whole documented form and stuff like that that includes the PHQ-9 and the GAD-7 for some evaluation...And we made a very big case to exclude people who have not utilized their EAP (PX17, p.11).

She addressed issues that result from high priority or urgent situations as well as her team’s waiting list:

After the intake a decision is made about what services [to provide]...group...individual...whatever...There also is a high priority process as well so we might have an intake done and say this person has to skip the whole list and come into therapy right away…(PX17, p. 11).

The above quote again illustrated how she prioritizes and manages her case load.

At the end of the meeting, she discussed that the funding model also added to the high volume of clients. She stated that, “the funding model is such that...we’ve had three social
workers from the beginning, which was 8 or 9 years ago, and the roster has gone up hugely…And so I feel like we lag behind, right?” (PX17, p.22).

Participant X17 continued to describe her experience with the funding model:

And so the funding model isn’t always seamless or reflect what the needs are...It is also the case where all the docs are...all the family health teams...are having to take on complex patients...That’s part of the funding model and they are having to take on whatever new patients from these complex referrals and...that comes with much more complex social work needs and mental health needs and the funding doesn’t give them that (PX17, p.22).

Participant X17 reflected on the need for doctors to provide service to all types of patients. She explained that, in her experience, doctors often felt pressured to provide service within the family health team context first before referring a patient to a specialist or hospital care. When referrals occur for specialized service, patients often were “bounced back” to primary care because the specialists feel that the patient’s needs can be handled within this setting. Participant X17 further discussed the impact of this pressure:

From these complex referrals comes more complex social work needs and mental health needs and the funding model doesn’t support that easily...You kind of struggle, struggle, struggle, until the burden is completely obvious...So I feel we are all being asked to do a great deal and increasingly, increasingly, increasingly, increasingly, you know, not just social work and mental health but everyone...everyone in primary care…and I have a hard time keeping up (PX17, p.22).
Participant X17 found these systemic issues increasingly difficult to manage. She acknowledged that the increase in patients and funding cutbacks have impacted her ability to do her job.
<table>
<thead>
<tr>
<th>Professional Background</th>
<th>Working with Patients/Clients</th>
<th>Working with Others (IHPs and Physicians)</th>
<th>Healthcare System</th>
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<tbody>
<tr>
<td><strong>Past Experiences</strong></td>
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<tr>
<td>- Trauma background</td>
<td>- More specialized services</td>
<td>- Recalls others’ challenges with isolation</td>
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<tr>
<td>- Front-line</td>
<td>- Trauma services</td>
<td>- Provided support to others</td>
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<td>- Hospital</td>
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<td>- Community Agency</td>
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<td><strong>Present Experiences</strong></td>
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<tr>
<td>- 30 years counselling</td>
<td>- High job satisfaction</td>
<td>- Positive working relationships</td>
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<td>- Clinical work</td>
<td>- Values relationships with patients</td>
<td>- High collaboration</td>
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<td>- Practice lead</td>
<td>- Very complex caseload</td>
<td>- Well defined collaboration (formal and informal processes)</td>
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<td>- Psychotherapy</td>
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<td>- Case management</td>
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<td>- Chronic conditions</td>
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<td>- Short-term brief</td>
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<td>- Long-term complex</td>
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<td><strong>Future Intentions</strong></td>
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<tr>
<td>- Collaborate with other mental health counsellors in other FHTs</td>
<td>- Determine priorities (i.e. what can we give up?)</td>
<td>- Need for greater understanding of mental health care in primary care</td>
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<td>- Supervision groups</td>
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<td>- Need for research</td>
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### Figure 4: Final Story Map: Participant X17

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<th>Working with Others (IHPs and Physicians)</th>
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<tr>
<td></td>
<td>o Trauma background</td>
<td>o More specialized services</td>
<td>o Recalled others’ challenges with</td>
<td>Lack of specialized services for trauma</td>
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<td></td>
<td>o Front-line</td>
<td>o Trauma services</td>
<td>isolation</td>
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<td>o Hospital</td>
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<td>o Provided support to others</td>
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<td>o Community Agency</td>
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<tr>
<td>Present Experiences</td>
<td>o 30 years counselling</td>
<td>o High job satisfaction</td>
<td>o Positive working relationships</td>
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<td>o High collaboration</td>
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<td>o Very complex caseload</td>
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<td>o Chronic conditions</td>
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<td>o Long-term complex</td>
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<td>Future Intentions</td>
<td>o Collaborate with other</td>
<td>-Continuing to use strengths</td>
<td>o Determine priorities (i.e. what can we</td>
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<td>mental health counsellors in other FHTs</td>
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<td>o Supervision groups</td>
<td>-Need to incorporate best</td>
<td>o Need for greater understanding of mental</td>
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<td>practices as articulated by</td>
<td>health care in primary care</td>
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<td></td>
<td></td>
<td>social workers</td>
<td>o Need for research</td>
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Participant P30

Character sketch. The researcher met with Participant P30 in her office, which was in a new building in a suburban neighbourhood. She reported that they had recently moved to the new building and that she was very happy to do so. Her office was bright and clean and the interview took place by the window. Participant P30 was also positive and conveyed a great deal of enthusiasm for her present position within the family health team. She explained that her background was in counselling and social work and that she had worked for 13 years in a government agency doing case management before becoming employed as a counsellor with this family health team. The transition was also as part of a social work school practicum. She continued to work in this setting after completing her placement. She has been working in this setting for the past two years and enjoyed her position very much. When describing her role as a counsellor, she reported having a specialization in addictions and explained that she primarily sees persons with substance abuse issues. She described her work as complex and very rewarding. The interview ended after almost two hours as the participant had much information to add.

First interview. The interview began with an explanation of the research process. The researcher went over the consent form again before turning on the voice recorder. Also a gift card to a coffee shop was presented as a small honorarium for her contribution.

Feedback from the second meeting and revised story map. The second meeting was a telephone meeting. The researcher shared the story map (see Figure 5) and coded transcript with her via email before this meeting. The second meeting lasted for 30 minutes and an explanation was given of how her transcript was coded, the story map was created, and how the researcher
came to identify the core message and themes from the initial interview. The follow-up questions were also given before commencing the second interview. Participant P30 said that she had found the interview helpful. She stated that overall the story map reflected her experiences working as a counsellor in her particular family health team. The researcher went through each column of the story map together and, upon further examination, she decided to add more information.

She discussed how her current work was more rewarding than her previous work in a government agency because she did not see as much progress or change in clients in her previous work. She reported that presently she had more job satisfaction since she saw more progress in her patients/clients. She explained that her past role was focused more on case management. After this discussion, Participant P30 elected to add two points under the heading of “Working with Clients/Patients”; these are underlined in Figure 6. Moreover, under the heading of “Working with Others on the Team (Interprofessional Collaborative Care),” Participant P30 stated that she would like further supervision in interprofessional care and that she would like to see how other members of the team function in their role with patients. These points were added to the story map and are underlined in Figure 6.

When discussing the final core message and themes, Participant P30 further stated that she felt the counselling role in general needed to emphasize client/patient self-management. She also indicated that, when working with clients/patients, language use was very important. She agreed with the final core message of “Specialized role” and the themes of “Ongoing professional development” and being “Valued by others for her expertise.” In addition, she shared that she had applied to MSW programs in social work and hoped to further her education in counselling and social work.
Figure 5. Initial Story Map: Participant P30

<table>
<thead>
<tr>
<th>Past Experiences</th>
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</thead>
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<tr>
<td>13 years case management experience</td>
<td>13 years case management experience</td>
<td>Worked with those with socioeconomic issues, complex issues</td>
<td>Recruited because of past experiences in social work</td>
<td>Economic downturn</td>
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<tr>
<td>Felt cookie cutter and wanted new experience</td>
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<td></td>
<td>Valued for having advanced understanding of FHTs</td>
<td>Socioeconomic issues impacting care</td>
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<tr>
<td>Additional education and career change</td>
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<td></td>
<td>Increased need for addiction specific counselling services in geographical setting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Present Experiences</th>
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</tr>
</thead>
<tbody>
<tr>
<td>New role</td>
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<td>Feels supported</td>
<td>Funding will not increase</td>
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<tr>
<td>Freedom to develop role</td>
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<td>Good referrals</td>
<td>Wage freeze</td>
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<tr>
<td>Luxury of more time compared to physician role</td>
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<td>Advocacy from some physicians</td>
<td></td>
</tr>
<tr>
<td>Addictions counselling</td>
<td></td>
<td></td>
<td>Feels hierarchy exists but not problematic</td>
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<td>Smoking cessation</td>
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<td>Seen as an expert by others</td>
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<td>Complex patients</td>
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<td>Each team member has specialization</td>
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<td>Brief care/short-term care</td>
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<td>Long-term ongoing supportive care</td>
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<td>Groups</td>
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<td>Referred by IHPs, physicians and patients themselves</td>
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<thead>
<tr>
<th>Future Intentions</th>
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<tbody>
<tr>
<td>Would like further education to develop clinical capacity</td>
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<td>More research on mental health in FHTs</td>
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<tr>
<td></td>
<td>Professional Background</td>
<td>Working with Patients</td>
<td>Working with Others on the Team (Interprofessional Collaborative Care)</td>
<td>Healthcare System</td>
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</tbody>
</table>
| **Past Experiences**  | o 13 years case management experience  
|                       | o Felt cookie cutter and wanted new experience  
|                       | o Additional education and career change | o Worked with those with socioeconomic issues, complex issues  
|                       |                                           | o More case management  
|                       |                                           | o Extremely difficult to see progress | o Recruited because of past experiences in social work  
|                       |                                           |                                           | o Valued for having advanced understanding of FHTs |
| **Present Experiences** | o New role  
|                       | o Freedom to develop role  
|                       | o Luxury of more time compared to physician role | o Addictions counselling  
|                       |                                           | o Smoking cessation  
|                       |                                           | o Complex patients  
|                       |                                           | o Brief care/short-term care  
|                       |                                           | o Long-term ongoing supportive care  
|                       |                                           | o Groups  
|                       |                                           | o Referred by IHPs, physicians and patients themselves  
|                       |                                           | o Sees progress  
|                       |                                           | o Emphasis on self-management | o Feels supported  
|                       |                                           |                                           | o Good referrals |
|                       |                                           |                                           | o Advocacy from some physicians |
|                       |                                           |                                           | o Feels hierarchy exists but not problematic |
|                       |                                           |                                           | o Seen as an expert by others |
|                       |                                           |                                           | o Each team member has specialization |
| **Future Intensions**  | o Would like further education to develop clinical capacity | o Wishes to develop more groups | o Would appreciate more supervision  
|                       |                                           |                                           | o Would like to see how other members of the team work with patients/clients |
|                       |                                           |                                           | o More research on mental health in FHTs |
**Final core message and themes.** Although Participant P30 agreed with the above core message and themes, she wanted to add an additional theme related to her approach to working with clients/patients. She termed the additional theme “Self-management approach.” The core message and themes are summarized in Table 2.

<table>
<thead>
<tr>
<th>Final core message: New specialized role</th>
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<tbody>
<tr>
<td>- Came to role first as student</td>
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<tr>
<td>- Was hired permanently due to demand for services in her area</td>
</tr>
<tr>
<td>- Specialized role: was hired to work with addiction patient population</td>
</tr>
<tr>
<td>- Focuses on building trust and an honest relationship with patients</td>
</tr>
</tbody>
</table>

**Theme 1: Ongoing professional development**

| - Values life-long learning |
| - Completed school project on family health teams |
| - Wants to pursue higher education |
| - Learns from patients |
| - Self-reflective approach |

**Theme 2: Valued by others for her expertise**

| - Positive patient feedback |
| - Positive coworker feedback |
| - Sensitive to hierarchical structure in organization (e.g. physician “veto power”) |
| - There are physicians who will advocate for her role |

**Theme 3: Self-management approach**

| - Primary goal is to foster patient independence and self-reliance |
| - Patients must set their own goals |
| - Wonders if this approach is helpful to complex patients who may require more support |
| - Overall approach is strengths based |
New specialized role. Participant P30 repeatedly referred to her role as being new and specialized. She stated that she had initially come to the role as a student but then was able to gain employment in the area due to an increase in demand for counselling services in family health teams. She also indicated that when she took on the position, it had never existed before and thus she had the opportunity to develop the role. She explained, “When I came here, because it was a new family health team, the role had not been developed so I got to develop the role, which is really neat. But the challenge was…what does the role look like? And, well, we’re not exactly entirely sure [laughing]” (PP30 p.6). She also expressed excitement about this new role and was appreciative of how it differed from her previous employment. She asserted, “I guess case management is a good way to describe it [my past employment]…kind of I guess…monotonous…I guess, maybe, because I’d been there for so long and there was no specialization…I think that would be it…You know, there was a huge number of us who could all do the same job where this one [my present position] is very different (PP30 p.7).

She explained that her role in the team is specialized even in comparison to other social workers who do not work with addictions populations: “The doctor might refer [patients] to the social worker. Or if it’s anxiety/marijuana use and struggling with finance…they would probably refer to me instead…if there was the addictions piece in there…the social workers have identified that they are not comfortable dealing with addictions” (PP30, p. 7). She described her role as specialized in comparison to other members of the team. She reportedly loved her new role and felt that it gave her room to develop as a counsellor.

She also described how her approach has changed as a result of transitioning from working as a general social worker to an addictions counsellor. She explained, “When I see smoking cessation patients, I am very cautious of my language and when we first sit down I say,
‘I understand that we are going to talk about smoking today,’ not ‘you are saying you want to quit smoking’…or ‘you’re here to quit’…or anything like that” (PP30, p. 21). Participant P30 further indicated that one of the goals of her approach is to build trust and honesty and to go “where the patient/client leads”. She explained, “Let them know it’s okay if it’s not the right time and, yeah, you thought it was the right time and you wanted to give it a go and excellent you are here to learn something from this journey and you’re going to build on this…but...is this the right time? (PP30, p. 22).

**Ongoing professional development.** One reoccurring theme during the interview was the value Participant P30 placed on life-long learning and ongoing professional development. She reported that she came to her present position due to a career change. After working for years in a social work capacity, she felt she wanted to change her role with clients and thus she went back to school to pursue further studies in social work. She explained that her journey had some complications:

I was working in [a government agency] for several years and started my BSW online and, then, when it came time to find my practicum, my placement, I had one set up and it fell through…so I was quickly scrambling and contacted the family health team in my city and the ED told me she didn’t have any spots but she knew of a family health team that was developing (PP30, p. 4).

From here she successfully interviewed for her present position. She indicated that she believes that she got this position due to having completed a school project on family health teams; this knowledge helped her get the job.
I went for the interview and it was interesting because one of the questions were…“Can you tell us what you think a family health team is?” and when I answered the two women who were interviewing me…looked at each other and said, “Nobody has ever gotten that question right”…and I’m like, well, I had done a project on family health teams in school so…I had the knowledge right at my fingertips and the good thing is that it makes sense to me when I read it [the model of care] I thought wow this is really cool how do I be a part of a family health team? (PP30, p. 4).

In addition to working in her present position, Participant P30 disclosed that she wanted to further her education by completing a master’s degree in social work. She described some locations she has been looking at and explained that her daughter is also in university and she could stay with her at the school that she attends.

Furthermore, Participant P30 was very reflective about her practice with clients/patients. She reflected on how she grows in her role by learning from clients. One reflection was that her goals may be different from the goals of her patients. For instance, describing a questionnaire that she gives to clients, she noted that

…there was a question that I put down there and it said “If you had a day to yourself what would it look like?”…I am just trying to engage people to open up to your possibilities and kind of look into those spaces that they’ve been closing off. And I got it back one time, this patient…and she is like, “I have every day to myself, that’s the problem…that’s why I drink” and I’m like, crap, I didn’t see that coming…learned my lesson well…I assumed because I want an entire day to myself with no responsibilities that everybody
else wanted it. But, you know…maybe the problem is…for some they don’t have that (PP30, p. 45).

As evidenced by the above statement, Participant P30 was very self-reflective in her approach to working with patients/clients.

**Valued by others for her expertise.** Participant P30 shared that she felt valued by others for her role as an addictions counsellor. She had received this feedback from both her clients/patients and other members of the family health team. She discussed her experiences with family physicians, noting “I feel there is a lot of respect from the doctors…the referral doesn’t come with a ‘do this for the patient;’ it’s more ‘please assist this patient with their…’ Whatever issue…their alcohol use or marital discord or, you know” (PP30, p.8). Later in the conversation she explained that,

There is one physician here though that will battle for us, which is fabulous…love her… and, in our last mental health meeting too, she said “I am so glad you guys do what you do because I have no clue how you do what you do and I’m so glad you are here to do it…I commend you...make sure you guys take care of yourself”…She was very appreciative (PP30, P.38).

She also described feeling valued by other healthcare providers on her team:

I do believe I’m skilled and she [the psychologist] tells me all the time, which is really nice…you know, because I’ll get a referral from her and she says, you know, “I need you to work your magic and do that awesome thing you do with your patients because I don’t know how to deal with this person” or “I don’t really know what I am doing” and so to kind of hear her use that language as a coworker, as an equal, is, umm, refreshing because
it just values me and, you know, I’m a valued member here too and I have a lot to contribute even though...I don’t have ‘doctor’ after my name or something like that (PP30, p.17).

This quote also suggested that a high level of rapport has been built between this participant and her coworker and how, in this case, her coworker was relying on her for her expertise.

Moreover, Participant P30 described feeling that her clients/patients also value her role:

Feedback’s been positive…they love it, especially people who don’t have a lot of finances …you know, when I do a smoking cessation appointment, I’ll always take a history and, umm, often times they’ll say “Yeah, I tried this before but I couldn’t do it on my own and knowing I was coming to see you kept me on the straight and narrow or kept me on my path” kind of thing (PP30, p.9).

This quote also helps to illustrate the importance of the counselling role and how in this instance the patient’s needed assistance and support when dealing with addiction.

Participant P30 discussed the hierarchy that existed in her family health team but said that her background in social work made her more sensitive to the issue, which was not heightened enough to impact her role:

in coming from a social work perspective, it’s like yeah the systems in place and there’s power imbalances and there’s going to be all the time and they’re going to be all over the place and how do you manage them, right? Am I, like, okay is this bad enough that I want to leave?…no (PP30, p.38).
Participant P30 had apparently come to terms with this dynamic. Although physicians have what she called “veto power”, she felt valued in her role and asserted that, overall, this power imbalance did not impact her practice. However, earlier in the interview she discussed an incident that left her feeling devalued or undermined:

Sometimes I’ll ask the docs their opinion on or how they, umm, feel about certain issues…The docs are great if you have a medical question…I had a patient come in and he was having his patch…it was not sticking anywhere on his body. He says, “The only place I haven’t tried is over my pacemaker and I’m not sure if I can put it over my pacemaker” so…I can go to him [the doctor] and say “Do you know of any reason why they can’t?”…and it is so funny because he says, “Why does he want to wear it over his pacemaker? He’s got so many other places to put it on”…That kind of put me off a bit because he’s tried everything else…that’s just one example of a time when…I kind of thought that I was made to feel like I didn’t know what I was talking about…or this physician is in such a go-go-go mode (PP30, p.34).

She explained that some physicians are more receptive than others to working with her. She said that, in her experience, most physicians were respectful but often it could get difficult because you were “dealing with people” (PP30, p.34).

**Self-management approach.** The final theme, which was added after the second interview, is that of Participant P30’s approach to working with clients/patients which she referred to as self-management. Upon rereading the transcript it became apparent that this was a common theme in the interview. This experience highlighted the importance of collaborating with participants for a second time since this approach can generate new information.
Participant P30 described using various approaches to foster client/patient independence and to promote self-management. She explained,

I’ll often say, you know, “Thank you very much for coming in because you could have just stood me up and not come here.”...and I also like to say that I don’t have any preconceived ideas of what I think they should or shouldn’t be doing and they will never hear from me “Well, you know you should”…“I may advise you on your health but this decision is yours and I don’t use scare tactics and I meet you where you are at. This is your journey...I’m the guide on the side”...(PP30, p.19).

By allowing clients/patients the ability to set their own goals, Participant P30 worked to foster independence. The client/patient determines when change is possible rather than being coerced into changing. She described using a similar approach working with groups. When asked about future goals for her work, she expressed wanting to lead what she refers to as “self-sustaining groups”:

That would be on my magic wish list so that people would eventually, you know, I would get them started and everything but, eventually, I wouldn’t need to be there…I would go in, set up the room, greet everyone…say “Hi everyone. How is everyone doing…doing okay? Great, I’ll come and see you at 11:30 and just do your own thing” and I could see more patients...(PP30, p.42).

She made this statement in reference to the types of groups she has run in the past which have been community based and supportive and thus she felt that they could have been led by group members themselves.
Participant P30 further stated that, although this approach is her ideal, it is not always one she takes with clients/patients. She wondered, at times, if this approach is helpful with more complex clients/patients:

You’re supposed to have goals...right…and so I think…it’s my, kind of, role to challenge them and [say], “Okay, this is what I am doing...what are you doing? And is this beneficial? What are you doing about this?” Sometimes when I have asked that question it’s, well, “I’ve just liked coming to see you”...and [I respond], “Okay, I like talking to you too; however, we need to…” (PP30, p.29).

The above quote indicates the need to have a purpose to counselling. This purpose may come in the form of a goal or objective. She reflected that often persons come to see her for support with no goals for change in sight. She reported some difficulty in not having an agenda with her clients.

She reported she often grappled with this idea of “doing something” with her clients. She described one way in which she received reassurance from her colleagues that what she was doing was helpful:

One of our docs…referred this patient to me and I remember after a few sessions going back to the physician and saying “Oh my gosh, she’s messed…like I feel like we keep doing this and this over again and we’re, you know, going nowhere”…and I said “Okay like, you know, am I helping?” And she said says, “We’re keeping her out of the emerg”…(PP30, p. 29).

Throughout her interview, Participant P30 shared stories of complex patients/clients. When it came to working with others, her primary goal was to use a strengths-based or self-management
approach; however, she recognized that, at times, this was not possible because some required more support.

**Participant B89**

**Character sketch.** At the time of the initial interview, Participant B89 was an experienced therapist who had been providing psychotherapy and counselling services within a variety of settings for over 30 years. She first worked as a counsellor in a hospital in two different areas. She decided to change jobs after completing her graduate degree in social work since a professor had told her that she would benefit from a new challenge. Participant B89 heard about the study from a mutual former colleague who had emailed her about the study. While the researcher knew of the colleague she had never worked with this participant. Participant B89 is retiring from practicing in a family health team. At the time of the interview, she was finishing her last two weeks of work in this setting and thought of the session as an exit interview of sorts.

**First interview.** This interview began 10 minutes late as the clinic was very busy and had a great number of patients waiting to be seen. It thus took some time for Participant B89 to be notified that the researcher was waiting for the interview. This particular family health team had multiple physicians as well as other healthcare programs located all within the same building. The interview began rather quickly since she reported she was under a time constraint. The researcher forgot to offer the gift card until after the interview had finished. The researcher ended up returning to her office but she was busy with a client so the gift card was sealed in a discrete envelope and reception was asked to put it in her mailbox. The researcher did not have a second interview with this participant because, despite several attempts to contact the participant for follow up, there was no response. This is perhaps because she is no longer working in this role as
she had disclosed in the first interview that she was retiring the following week. The core message gathered from the interview was the need for “Professional advocacy” and the themes were “Complexity of role,” “Need for advanced clinical knowledge”, and “Creating safe relationships with patients/clients.” This information is summarized in Table 3.

<table>
<thead>
<tr>
<th>Table 3</th>
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<tbody>
<tr>
<td><strong>Participant B89</strong></td>
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<tr>
<td><strong>Final core message: Professional advocacy</strong></td>
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<tr>
<td>• Mental health counsellors need to advocate for their role</td>
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<tr>
<td>• Important not to internalize hierarchy</td>
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<td>• Will be “tested” by other team members</td>
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<tr>
<td>• Need to “push back”</td>
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<tr>
<td>• Need to know self-limits</td>
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<tr>
<td><strong>Theme 1: Complexity of role</strong></td>
</tr>
<tr>
<td>• Mental health counsellors need to be experienced</td>
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<tr>
<td>• Long-term relationships (i.e. counselling without termination)</td>
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<tr>
<td>• Similar practice to that of a family physician</td>
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<tr>
<td>• Need to learn new model of care while still remaining true to scope of practice</td>
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<tr>
<td><strong>Theme 2: Need for advanced clinical knowledge</strong></td>
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<tr>
<td>• Very difficult practice</td>
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<tr>
<td>• Would not have chosen the setting if she could do it again</td>
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<tr>
<td>• Isolated role so need to know what you are doing</td>
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<tr>
<td>• Need to work with minimal supervision</td>
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<tr>
<td><strong>Theme 3: Creating safe relationships with patients/clients</strong></td>
</tr>
<tr>
<td>• Mental health counsellors are a constant in the lives of patients</td>
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<tr>
<td>• Luxury of time allows the creation of safe relationships</td>
</tr>
<tr>
<td>• Need for transparency with patients</td>
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<tr>
<td>• Only sharing medically necessary information with other members of the team</td>
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**Final core messages and themes**
**Professional advocacy.** During the interview, it became apparent that Participant B89 felt that mental health counsellors needed to advocate for themselves within the context of the family health team and the healthcare system in general. She also asserted that it is important not to internalize a hierarchical way of relating to other professionals in the team. She stated that she does not feel a hierarchy existed within a family health team, she felt it is created by those who lack professional experience in their role. She felt that inexperienced counsellors may not appreciate this sentiment and therefore answer to other members of the team. This sentiment suggested that at times team members who are experiencing difficulty are not supported. She recalled her first experience working with a family physician:

"I still remember my first interview with the family physician and he said to me, “There's just one thing I ask of you” and I said “What's that?” and he said “That we don't have a wait list” and I remember when I started that job...that I had already been an experienced social worker...but I felt very overwhelmed…I felt alone on an island (PB89, p.2).

Participant B89’s experience with the physician requesting that she not have a wait list taught her early on in her work in a family health team the importance of self-advocacy. She recognized the need to set limits with physicians from the first day and to assert her approach to counselling. She later stated that she experienced “push back” from physicians. She explained that she tried the best she could to provide effective counselling given the limited amount of time that she had with clients. Reflecting on this physician’s perspective, she speculated:
## Figure 7. Final Story Map: Participant B89

<table>
<thead>
<tr>
<th>Professional Background</th>
<th>Working with Patients/Clients</th>
<th>Working with Other Team Members</th>
<th>Healthcare System</th>
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<tbody>
<tr>
<td><strong>Past Experiences</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Specialist</td>
<td>o Insight oriented approaches</td>
<td>o Isolated</td>
<td>o Demands from physicians</td>
</tr>
<tr>
<td>o Hospital</td>
<td>o Talk therapy</td>
<td>o Good working relationships</td>
<td>o Model practice alongside physicians</td>
</tr>
<tr>
<td>o Solo physician setting</td>
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</tr>
<tr>
<td><strong>Present Experiences</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Clinic setting</td>
<td>o Behavioural approaches</td>
<td>o Need not to internalize hierarchy</td>
<td>o Lack of resources</td>
</tr>
<tr>
<td>o Generalist</td>
<td>o Action/change approaches</td>
<td>o Need to educate the team about the counselling role</td>
<td></td>
</tr>
<tr>
<td>o Luxury of time compared to physicians</td>
<td>o Complex issues/trauma</td>
<td>o Need for team to understand the role</td>
<td></td>
</tr>
<tr>
<td>o Consistent person within the family health team</td>
<td>o Short-term work</td>
<td>o Need to set limits/boundaries regarding expectation of scope of practice</td>
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<tr>
<td>o Role needs to be given to more seasoned therapists</td>
<td>o Long-term relationship similar to family physician</td>
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<td></td>
<td>o Creating safety</td>
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<td></td>
<td>o Listening</td>
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<td></td>
<td>o Collaboration</td>
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<td></td>
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<tr>
<td></td>
<td>o Slowing down</td>
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</tr>
<tr>
<td><strong>Future Intentions</strong></td>
<td></td>
<td>o New areas in the field</td>
<td></td>
</tr>
<tr>
<td>o Changing focus</td>
<td>o Compassion</td>
<td>o Need to set limits/boundaries regarding expectation of scope of practice</td>
<td></td>
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<tr>
<td>o Winding down</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>o Coming full circle</td>
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</table>
I think his biggest anxiety was that we not carry or have people on a wait list for a long time so I just said to him that we are going to do our best. That is probably one of the biggest challenges when the referrals come in is, you know, how do we manage them? (PB89, p.4).

The phrase “doing our best” seemed to allow Participant B89 a means of setting limits with the physician and her coworkers. As she indicated, she was not going to work faster because someone on the team is asking her to; she was setting her own professional limits with herself and with others. This approach is key when working in a family health team. Her fast-paced work environment illustrated the importance of setting boundaries in order to protect herself and her ability to practice safely and competently. She addressed the need for self-advocacy again later in the interview:

I think, you know, when you work in primary care you have to know what your limits are because based on the nature of the model...our scope of practice is pushed to the boundaries as it is...so people in this chair really have to know what their scope of practice is (PB89, p.14).

When she discussed seeing adolescents, Participant B89 reflected on the importance of having boundaries and “pushing back”:

I never used to see adolescents and, based on need, I started seeing adolescents and I had no background...We had a need to see children and I’ve seen a few children…it’s just not good for me to do so...And, again, I have a luxury…I have other colleagues if there is someone here who does see children but what I mean is it is important to go out of your comfort zone (PB89, p.15).
Participant B89 identified the importance of striking a balance between challenging oneself to develop professionally while recognizing personal limits.

Participant B89 disclosed that she is retiring and that this meeting provided a chance for her to reflect on her past 16 years practicing in an interprofessional setting. Her warning to new counsellors was that one needed to come to the role with experience. For instance, she asserted,

“I think you need to have some experience…to really know community resources...how to advocate for a client with the physician when the physician’s pushing back because I don’t see this as a hierarchy...I see this as lateral. But maybe a new grad might see it is as a hierarchy” (PB89, p.17).

When asked about the hierarchical nature of medical models and how her perspective differs from the literature, she responded:

Well, that’s one’s perception or that’s how you set things up pretty early...Anyone coming into the job is going to be tested…and pretty inappropriate referrals so it’s really important to set boundaries and be clear on your role...your scope of practice” (PB89, p.17).

She discussed the importance of not internalizing old hierarchical medical structures. She maintained that one must behave professionally in order to promote what she called “lateral” relationships with other team members.

Complexity of the role. Participant B89 used the term “complex” on several occasions to describe the counselling role in family health teams. She maintained that the complexity of the role provided a rationale for hiring more experienced social workers/counsellors. She described
patient/client issues as being complex. She also discussed impacts of this complexity on her
coping and her practice. When describing her first impressions of the role, she noted

“I couldn't believe the amount of complex cases, families, everyone was different, every
person had obviously a unique story but it was pretty overwhelming for me, I would say,
the first couple of years” (PB89, p.3).

This pointed to her belief prior to coming to the role that cases she would see would not be as
complex. She spoke about feeling like she was alone on an island. Although an experienced
therapist when she came to the role, she found the role very difficult but she tried her best to help
clients. She also reflected on working with clients:

“How do you discharge someone? Well, you can discharge someone but you can’t
because…it’s a trusting relationship and if the relationship has worked then we’re part
of their journey even though we may not see them or hear from them for a year or two”
(PB89, p.5).

Participant B89 reflected on the similarity between her counselling practice and how a family
physician practices. Just as family physicians cannot discharge their patients, the counsellor
rarely officially terminates relationships with their clients. Counsellors remain a constant in the
client’s life and, while they may not see the client regularly, they are there should the need arise.
She added:

“Because in a lot of ways we carry these people...not forever but for years because their
counselling may have stopped...they have moved on...but in two years there is a crisis or
something’s triggered...a loss...so they call again” (PB89, p.5).
Participant B89 reflected on the long-term relationships that counsellors in family health teams have with their clients/patients. Counselling may occur over a long period of time with frequent or long breaks in between sessions. This irregular contact can make the counselling process quite difficult. The counsellor must be flexible and work from the client’s level of functioning. When patients/clients are not available for ongoing sessions or need longer-term support, it can be difficult to enact short-term protocols. Employing short-term protocols that rely on weekly sessions may also be inhibited by the counsellor’s lack of availability within the context of this often hectic working environment.

Participant B89 also spoke about the complexity of counselling work when compared to the work that is performed by other members of the family health team. She noted that certain nuances may go unnoticed by other team members:

I think the other thing is that often people looking in might see our templates with direct patient care and they don’t see all the work that goes on before and after...When I started here my template was already booked…there was no orientation to the role... to patient care...I tried to educate the staff on the real nuances of what we do…It’s not just about a 50 minute session (PB89, p.18).

It became clear during the interview that Participant B89 felt the need to explain the complexity of her work to others in her family health team. She further added:

“So as you try to put on paper, formulate what it is that we do...it’s very complex and is not always tangible. And I know for myself I often can’t articulate what I do...How do you tell somebody about establishing a therapeutic relationship? About safety?” (PB89, p.20).
She also discussed an appreciation that her family has of her work and that this has reminded her of what she can do. Reflecting on a conversation she had with her daughter, she noted:

I have a daughter who is now in university and, you know, she’s taking a couple of courses that kind of touch on the field [of social work]…I’ll just tell you a quick story…She had somebody come talk about how to assess for suicide and so she said to me…“I didn’t know you did that”…She was just in awe that I knew and that I do assess people for suicidality…It was very interesting to kind of hear those kind of comments”(PB89, p.20).

Need for advanced clinical skill. Due to the need for professional advocacy and the complexity of the role, Participant B89 stated that counsellors/social workers who practice in family health teams need to have what she calls “advanced clinical skill.” She stated that, if she were to do it all again, she probably would not have gone into primary care counselling. She made the change later on in her career and she took the job because it fit with her lifestyle. It was part-time and had a flexible schedule so that she could also dedicate time to being a mother and raising her children. She reflected on the need for counsellors who are working in this setting to be experienced:

choosing it [this job] later in life was actually kind of wise…I can’t imagine young grads doing this job…I kind of feel a little concerned…I pay for supervision…and I meet with peer consultation every two weeks…and I learned everyday…It’s been a really, really, interesting learning curve so I did step out of my comfort zone in terms of a specialty clinic…I did become a generalist…I like the challenge of everybody coming in is
different...there are no two people alike...no two stories alike...I like the team approach...I like to collaborate with the team...the interdisciplinary team (PB89, p.16).

The above quote illustrated challenges with needing advanced skill but Participant B89 demonstrated how she compensates for these challenges. Participant B89 explained that mental health counsellors in family health teams may be isolated and act independently. This may be a choice or this may be because of lack of support from other team members. In this role, she does not have access to clinical supervision; counsellors at her practice who want supervision have to pay for this at their own expense. This is true of all counsellors in family health teams. It is thus understandable that there are many counsellors/social workers who do not access supervision. Supervision is not a requirement and it is widely assumed that someone who is taking on the role of counsellor/social worker within a family health team has a high level of clinical knowledge and thus they do not need access to an onsite supervisor or regular case management and/or supervisory meetings. This view differs from other views of the importance of lifelong learning as a counsellor. The researcher understands that no matter how many years of clinical experience you have or how “seasoned” you are, ongoing supervision is essential. Not having supervision may be harmful given that self-reflection as a counsellor/therapist is of great importance. This illustrated the need for supervision and stressed the importance of personal growth and self-care.

Creating safe relationships with patients/clients. Reflecting on her approach to counselling, Participant B89 stated that she is a constant within the lives of patients who come to see her in the doctor’s office. She explained that she has more time to spend with patients than other allied health professionals and family physicians, and referred to this as having “the luxury of time”. She outlined her dedication to establishing a solid rapport with clients/patients and building safe professional relationships. She explained that her goal
first and foremost is to establish safety...to establish rapport...to really give someone the opportunity to slow their lives down...to really reflect on why they are here and what they want to work on...It takes great courage for someone to come in and speak with a stranger and share a piece of their journey with us and to help people understand that I am trustworthy...I will hear their story and we will do our best together to come up with a plan and to move forward with that plan (PB89, p.7).

Transparency in regards to the new model of family health teams was a priority for her. She later explained that she was transparent with clients/patients about the family health team role and would take time to explain how family health teams work:

I like to share and I say this to all my clients, “We work in a team and...you know, I do have to put something in the chart and what I put on your chart is something that is going to be relevant for your care so that there can be a story and that story can continue” and so if it’s a difficult situation, if it’s something that I think the physician needs to know because, you know, the person is coming to see them next week...if it’s about a medical management I think it’s really important [to share information] obviously (PB89, p.13).

She recognized her role in information sharing but only shared medically necessary information with family physicians. This approach may aid in building trust between the counsellor and patient/client.

**Participant A24**

**Character sketch.** At the time of the initial interview, Participant A24 was a social worker with 17 years of experience working in the area of community mental health. She described having a research background in the area of primary care and shared that her interest in
the research project stemmed from her own research interest in the area. She had heard about the study as a result of recruitment materials being mailed to her family practice. She also mentioned that she had shared information about this project with colleagues in her region.

She began her career in a hospital setting. Although she found that this setting was an ideal one for her, she wanted a change and thus, after completing a master’s degree in social work, she applied for her present position as practice lead and social worker with her family health team:

I just didn’t want to spend decades there [at the hospital] so I chose to go back to school and went back and got my Masters and during that time I connected with a researcher at [my university] and actually did a research fellowship in primary health care, multidisciplinary research. So that I think kind of got me into the family health team and I was able to connect with people from all different disciplines to work on a project for a year, which was neat. So then at the time I was finished my Masters and the funding had just started coming through in [my city] for a family health team so I guess I got one of the first positions (PA24, p.2).

Participant A24 was very warm and inviting and seemed to be genuinely interested in answering the interview questions. Her interests were akin to the researchers and the interview went smoothly and lasted approximately 90 minutes.

**First interview.** The meeting took place in Participant A24’s office during a busy work day. There were a large number of people in the waiting room of the clinic. The interview commenced on time and the research process was explained and the participant consented to questions and being voice recorded. A small gift of a $10 gift card to a nearby coffee shop was
offered and the interview begun. Approximately a quarter of the way through the interview she needed to pause to take a phone call. Although this call did not disrupt the flow of the session, it is worthy of note since it reflected the fast-paced nature of this primary care setting. The initial story map was created during the analysis phase of this interview. Participant A24’s core message was identified as “I love my job” and the themes of the interview to be “complex and challenging work” and “Inspiring change”.

**Feedback from second interview and final story map.** The interviewer met with Participant A24 for a second time after sharing with her these initial results. This interview occurred via telephone and lasted approximately 40 minutes. In addition to her story map the present wage freeze and the recent unionization of some family health team mental health counsellors in Ontario were discussed. She also asked if the interviewer was aware of the program evaluation report that had been published recently on family health teams in Ontario. This new report was shared with the writer. The researcher also discussed her data, she was asked if the story map accurately reflected her experience of working within a family health team and if there was anything missing or if there was anything that she wished to add. She stated that she felt the researcher had accurately depicted her experiences.

When discussing the story map and data analysis, she seemed impressed by and excited about the research project. The story map was examined and she stated that, upon reflection, she did not feel that a hierarchy existed within her family health team and did not think that was an appropriate word to use to describe her team. The researcher asked her to further clarify and she replied that she felt that while family physicians had more responsibility within the family health team role because they are the most responsible for medical care, she did not feel that there were any issues related to power and control within the team. The information in the story map was
### Figure 8. Initial Story Map: Participant A24

<table>
<thead>
<tr>
<th>Professional Background</th>
<th>Working with Clients/Patients</th>
<th>Working with Others (Interprofessional Collaboration)</th>
<th>Healthcare System</th>
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<tbody>
<tr>
<td><strong>Past Experiences</strong></td>
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<tr>
<td>o Specialist role</td>
<td>o Longer hours</td>
<td>o Hesitation at first</td>
<td>o New funding</td>
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<tr>
<td>o Hospital</td>
<td>o Further training</td>
<td>o Need time to build trust</td>
<td>model</td>
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<tr>
<td>o Research project</td>
<td>o needed for working with</td>
<td>o Create relationship with physicians</td>
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<tr>
<td>in primary care</td>
<td>complex patients</td>
<td>o Communicate about role</td>
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<td>o Serendipitous events</td>
<td>o Trauma training</td>
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<td><strong>Present Experiences</strong></td>
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<tr>
<td>o Flexible</td>
<td>o Complex patients</td>
<td>o Well-established relationships</td>
<td>o Wage freeze</td>
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<td>o Luxury of time</td>
<td>o Psychiatric issues</td>
<td>o Trust</td>
<td>o Lack of</td>
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<tr>
<td>o Scope of practice</td>
<td>o Social issues</td>
<td>o Valued</td>
<td>resources</td>
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<td>often pushed</td>
<td>o Brief services</td>
<td>o Sympathy for physicians</td>
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<td>o Need to balance</td>
<td>o Long-term intermittent</td>
<td>o Feel hierarchy is due to funding model and increased liability</td>
<td>psychiatry</td>
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<td>what can and cannot do</td>
<td>services</td>
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<td>o Increase in demand</td>
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<td><strong>Future Intentions</strong></td>
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<td>o Continue to learn</td>
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<td>o Continue to involve team in mental health care</td>
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<td>about new areas</td>
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<td>o Competitive compensation</td>
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revised. All of the changes are reflected in Figure 9 and new additions are underlined. This conversation presented the opportunity to reflect on the research process. Perhaps, in this instance, misinterpretation had taken place and hierarchy was not a good use of language.

**Final core message and themes.** Table 4 summarizes Participant A24’s final core message and themes.

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<tr>
<td><em>Participant A24</em></td>
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<tr>
<td>Core message: I love my job</td>
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<tr>
<td>- Novel and new opportunity</td>
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<tr>
<td>- Constantly challenged to learn something new</td>
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<tr>
<td>- Growth in skills</td>
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<tr>
<td>- Flexibility and independence in role</td>
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| Theme 1: Complex and challenging work |
| - Need to view patients with mental illness as people who are operating within a larger context |
| - Complexity in managing caseload |
| - Long-term patient relationships |
| - “Jack of all trades” generalist approach |

<p>| Theme 2: Inspiring change within the interprofessional context |
| - Cultivating positive work relations |
| - Overcoming challenges |
| - Encouraging allied health professionals to take on mental health care |
| - Quiet eliciting and patient collaboration |
| - Need to have an understanding of the systemic issues that may interfere with collaborative care |</p>
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<td></td>
<td>o Increase in demand for services</td>
<td>o Differences in roles but not hierarchy</td>
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<td>o Waitlists</td>
<td>o No Power imbalance</td>
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<td>Future Intentions</td>
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**I love my job.** It was clear throughout the interview that Participant A24 experienced job satisfaction. While she identified challenges involved with working in a family health team, she also spoke about her present position as being ideal for her because she was afforded the opportunity to create something new (the role of mental health counsellor in family health team settings) while still being able to practice her counselling skills that she had developed throughout the years.

That’s what I love about it [my job]...I’m constantly challenged...I’m constantly checking the databases...looking things up...Oh, this is new...How do I?...I wonder how I deal with this? Constantly reading...but I love that...that keeps me challenged… [My job is] never boring (PA24 p.19).

Although she had come to enjoy and appreciate her job, Participant A24 explained that when she started working in the family health team she faced many difficulties. She described these difficulties as isolation and lack of communication with other coworkers:

I was the only one here initially. Then we hired a few more [social workers] so for a little while it was just a small group of us and that was difficult too because we were all at different sites and we didn’t really connect other than virtually through email. But as with any organization starting up...for the first few months…I didn’t have a computer...I didn’t have email…you know I didn’t even have a phone extension…I mean it was pretty basic so you felt quite isolated at first…It’s completely different now (PA24, p.5).

She spoke of an evolvement of her role over time. She reported that currently she is satisfied with her role but that this was not always the case.
Towards the end of the interview she described additional challenges such as difficulty with involving other members of the team in mental health care and confusion regarding confidentiality and the shared access to information. When asked why she stayed in this job, she responded:

Well the one thing the job offers is a challenge which is what I love and I love the flexibility which you wouldn’t have in the hospital…When I heard the difference in pay, when I heard the difference from the hospital, I was going to turn it down and they said, “Well, what else can we offer you?”…and I said, “Well, I have young kids…I would love to work 9 to 3:30. Can I do that while the kids are in school?”And they said, “Sure” and I was like “Wow” and so things like that…I think we get people in these jobs that love it and, umm, that make it work for their family life so, yeah, you might be losing on benefits and wage and most of us have a partner that does have benefits in some way. So I think you tend to get that type of person (PA24, p.33).

The above perspective illustrates an essential quality needed in order to work in this particular setting. Participant A24 demonstrated an enthusiasm for challenge and although she admitted that it was not always easy, she has developed a way of coping with the challenge that has made it very fulfilling to her. It then becomes essential for mental health counsellors to be able to figure out ways to manage the challenge. Therefore, this role would be suitable for those who are up for the challenge.

**Complex and challenging work.** Participant A24 described her work as challenging and complex. This challenge can be seen in the patient population and their accompanying health
She outlined the types of patients/clients she works with and how assessing the client’s initial symptom presentation can lead to the identification of larger, more complex issues:

Typically depression…anxiety…relationship issues…would be the top three [referrals]…a lot of grief and loss…I keep my own numbers…I’d say about 30% of the clients that I see have a history of childhood trauma…So that was a real piece…an eye-opener for me really that that was so prevalent in the population of people I was seeing…So I’ve had to kind of go out and get extra training…because it’s so prevalent. So I think that’s what I get because [they]…present to the physician as depression or anxiety but really what we are looking at is complex trauma and effects of trauma and sometimes that’s the difference. And I can see in the physician’s mind [that] perhaps they would see [these patients] as resistant to medication (PA24, p.6).

She also identified complexities and challenges with regards to managing her increasing caseload of patients/clients:

When they [patients/clients] come in it says that we practice short-term, solution-focused [counselling]…I don’t actually put a number on that but I’ll verbally say, you know, “Short-term I see as being ten and under”[sessions] but, quite frankly, I have to make sure I manage my caseload because some may need a bit longer and part of that is that there is nothing in the community or there is no psychiatrist or they are waiting a year and a half to get into the trauma program and they need some sort of support…I almost feel that I fill the gap and that could be a year and a half…So I have to be careful I don’t get all those types of clients in my caseload…And it’s certainly a struggle…It really is a struggle (PA24, p.16).
This speaks to the complexity of the referrals and of case management. Counsellors will intend to offer a short term approach but then need to reevaluate whether or not the client needs more support. Also a definition of what constitutes a short term counselling relationship is variable. In this case the participant felt that short term was approximately 10 sessions or less.

She also described the setting as being challenging when talking about frequently seeing complex clients/patients:

You get a little bit of everything...You have to know a little bit of everything or at least know where to go to find out that information…Right? (PA24, p.18)

She described herself as having a “jack of all trades” approach. She said this approach is drastically different to the one she used when she worked in a hospital where her role was more specialized.

She explained that she loved her work because of the fact that it is so complex and challenging. One challenge she identified is being pushed in her role:

In general I’m always being pushed…I don’t think it’s something that is out of my scope but it might be something that I haven’t done a lot of so I think you need a certain type of person in this role...someone who is willing to go…what I really need [is] to read more about this...That’s the one thing that really keeps me going and allows me, I think, to expand my role. So I guess here I feel my role is pushed a little bit more than it would be somewhere else but then my personality is okay with that and, again, if it’s something that I’m totally unable to do I’ll declare that (PA24, p.20)
**Inspiring change.** Participant A24 stated that while there are various challenges to working in an interdisciplinary team environment, over the years she has cultivated positive working relationships. For instance, when beginning to work in her current family health team, she gave the physicians in the practice time to adapt to her presence. She explained:

It was interesting when I first came…the physicians were not used to working with social workers...They were older physicians and I think they hadn’t been exposed to that in their own training. So, quite honestly, when I first came here I wasn’t doing much of anything…because, honestly, they didn’t know what to refer to me...So that took, I will say, about six months...where we got to the point where “Oh I can refer this” and “I trust your opinion”…I was very mindful of the fact that the physicians had relationships with the patients for decades…And so, in some cases, I don’t want to kind of come in and look like oh I’m taking over the mental health care or anything like that. So I was very mindful of respecting and involving the physicians…Things in the hospital I would just have normally kind of done on my own (PA24, p.3).

Participant A24 also described encouraging other allied health professionals to take on responsibility in providing mental health care. For example, she involved nurses in triaging the mental health service:

So we did involve the RN role in that...There was a bit of uncomfortableness I think around that…I wouldn’t say push back but a little coaxing I think…They haven’t typically done that role before but it certainly was within their scope of practice...that triaging piece...We did involve the practice lead...to get her blessing (PA24, p.21).
She described her style of collaborating to be a quiet and patient one. She would take a step back and allow time for the relationship to develop between her and her team members.

Furthermore, she spoke about her relationship with her team members being very respectful. She did not feel that a hierarchy existed in her family health team:

Here I’d say…I feel very respected…I don’t feel when you say “hierarchy” that there is a hierarchy…That’s almost a role hierarchy because they [physicians] have certain obligations legislated to them that I don’t have…Mental health wise they would have to fill out the Form 1, you know, things that I am not able to do from a legislative perspective…Our roles are almost dictated to us differently…I feel very respected…I don’t feel that when we work together there is a hierarchy…There’s a hierarchy imposed on us by the powers that be(PA24, p.34).

Participant A24 did not think that the term “hierarchy” was an appropriate descriptor for her workplace because she is treated with respect within her team. However, she did recognize that physicians have additional obligations and thus there is a structural “hierarchy” at work within family health teams. Notably, this structure did not cause her to feel like a less valuable member of the team.

It became clear during the interview that Participant A24 had a great understanding of the system and the pressures placed on various members of her team. She reflected that resistance to the current model presumably came from other team members had a different mindset because they had different responsibilities:

They [physicians] come from a small business model before we were there and, for them, it’s all about dollars. And not only that, they are still paying their staff…they are paying
their overhead...They have huge expenses, I’m sure, so for them to go for a meeting is a big deal because in the past that means they are not billing...They still have all their patient work so, for us, who are on salary, it’s like of course we are going to go to a meeting. But it’s just a different mindset from where they come from as well, right? (PA24, p. 37).

Participant A24 articulated an advanced understanding of the dynamics associated with the current funding model. Physicians are not salaried employees, like mental health counsellors, and so therefore have a different mindset when it comes to services that cannot be billed.

**Participant D22**

**Character sketch.** Participant D22 was a social worker with an educational background in psychology, social work, and nursing. At the time of the interview he reported a varied clinical background, working both in hospital and community agency. He also had management experience. It was through his graduate work in social work and research that he came upon the family health team role. The encounter, much like participant A24, occurred quite serendipitously when he began his clinical internship with a family physician that had hired social workers within their family practice. He reported that this physician was one of the main proponents of the family health team model and the reason why he was able to continue working within this particular family health team. Participant D22 appeared to be very knowledgeable about the field. He was also very enthusiastic about the present research project and in particular how to best function within teams. He reported that the area of collaborative care was a research interest to him and in particular how one’s perception of another’s role can influence referral practices. The interview took place in his office, another new building, at the end of the day. The office was
clearly closed with the reception window darkened. Participant D22 shared he was finished seeing patients for the day and that he had as much time as needed for the interview. The interview went smoothly and the conversation lasted for approximately 90 minutes.

**First interview.** Participant D22 had already printed off the consent form and shared that he had familiarized himself with the questions. Additional information was provided on the purpose was of the interview. He shared that he was very interested in this research as he felt it directly applied to his area of practice. He consented to being audio recorded and did not have any additional questions.

**Feedback from second meeting and final story map.** The researcher met with the participant once again to discuss his story map and to receive feedback on the initial interview. The meeting was via telephone and lasted approximately 30 minutes. During this time the researcher asked for his feedback on the story map and if he wanted to add anything to the analysis. Initially he responded that he felt the analysis had accurately depicted the interview and his experiences. Upon further exploration he added more information under the heading “working with others/collaborative interprofessional care” that one needed to be mindful of change fatigue. He referred to a time in his own practice when an initiative was presented and not received well by others in the team. He felt that perhaps there was too much change occurring and that the initiative presented was met with resistance from others because they felt unable to take on more tasks.
### Figure 10. Initial Story Map: Participant D22

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<tr>
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Another item that he added was under the healthcare system heading. He disclosed that since the first meeting he had discovered that his hope of an addition of a new social worker to his team was not going to be possible. He received the news that despite the increase in number of patients rostered there would be no more allotted social work hours. He added that this meant reevaluating his own practice in order to accommodate for the increase in caseload. These additions are reflected in figure 10 by underlining.

The core message of needing to understand our role was kept, but Participant D22 shared that he felt that needing to understand how best to function within teams was equally essential and not just another subtheme. He recommended having two main core messages as he felt that both points were of equal importance.

Another point that was discussed in this meeting was that of counselling practice. The researcher shared thoughts about how counselling practice can be conceptualized as either short-term solution focused or longer term case management, based on findings from his experience and feedback from other participants. He agreed and further indicated that perhaps out of this research one could propose a new model for counselling in primary care (which will be discussed in chapter 5). Further discussion occurred about the interesting phenomena of counselling in family health teams which he felt is unique as this practice often mirrors that of the family doctor. This is a similar sentiment expressed by participant PB89 and will be discussed further in chapter 5.

The differing process of counselling, which was discussed in this second meeting with participant D22, was that of recurrent care. Participant D22 shared that he felt his work with patients/clients was often different from that of traditional counselling relationships where this is
a beginning, middle and end of relationship. He states that while there are some clients/patients that he ends relationships with, there are others that he sees recurrently, often at times with months or even years in between sessions.

At the end of this second interview Participant D22 shared that there was a new Primary Care Council of Ontario which had recently been created which had a mandate to look at best practices. He stated that he was presently discussing having a social work presence on the council. It is interesting to note here that the mental health counsellor/social worker role was not seen as a stakeholder within the council and that this participant is advocating for a place within this new organization.

**Final core message and themes.** From the second meeting the core message and themes were confirmed. The core message was need for understanding best practices within the counselling role as well as how best to function within teams. The themes are working with patients in ways that empower; and valuing interprofessional care. This information is summarized in table 5.

| Table 5
| Participant D22

**Core message: Need to understand best practices**
- There is not a lot of research on mental health counselling within family health teams
- Wondering if what I am doing is helpful
- Need for standardized methods

**Core message: Need to understand how to work best within interprofessional teams**
- Initiating collaborative care is often difficult
- Physician buy-in is key
- Often encounters “change fatigue”
- Need to understand the timing of new projects/initiatives within the organizational
### Theme: Empowering patients

- The onus for change is placed on the individual patient
- Short term work is beneficial
- Long term work may not be helpful and create interdependence
- Important to inspire hope

### Theme: Valuing collaborative care

- Inspiring physician who pioneered this approach in his area
- Previous research experience on the topic
- Feels respected within the larger family health team
- To sustain collaborative care, recruitment of physicians who have similar values is key

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**Understanding best practices.** Throughout the interview with participant D22 there was the message of needing to understand best practices, both within the role of counsellor as well as team member. His decision to participate in this project was directly related to his idea that mental health providers need to understand best practices:

> There is not an awful lot that’s come out about our role so there’s a bit of a vacuum of knowledge right now…it (this research) looks directly applicable of course to what we are doing day to day so I’m curious to see what other people are thinking about the role…where they see it going…what the challenges are, how the collaborative process works or doesn’t work…so I would love to see what other people are finding out about it…(P5, p.3).

Participant D22 was also interested in knowing if the approach taken with clients/patients is the best approach. He admitted that often he wonders if what he is doing is helping:
…that was a discussion too, when I started because some of the physicians thought, you
know, maybe there are some people (patients) who are constantly chaotic and
problem…maybe just take sort of a case management approach role, which might mean
seeing them forever…but it’s a little harder to say how do we know that that’s
helping…how do we show that that’s made any difference at all? Because there is a very
good chance that it hasn’t…and it is interesting to try and prove that what we are doing is
having a positive impact, not just for patients but for the system, so are physicians doing
less counselling and how do we prove that’s true…do we make fewer referrals? How do
we show that? (PD22, p.15).

Further to this question, he pointed to the need for standardization of approach. He discussed how
those in this particular position come from a variety of backgrounds with a variety of approaches
and they are presently in the process of blending their strengths:

You know I come from a very medical background and my form has a pretty ‘hospitaly’
medically feel to it…whereas some of the other social workers came from you know out
in the community and had a lot of experience with trauma and counselling with abuse and
stuff like that so they bring their strengths too so we’re blending that to come up with a
form that will have them create a template within our computer system so that we can fill
it out in a standardized sort of way and once again keeps us again goal focused and
naming the modalities that we think we are going to use and with each visit we’ll revisit
that...are we doing what we thought we were going to do...did we encounter a problem we
didn’t even know existed? Are we making progress? Aren’t we? Are we stuck? Are we
going backwards? (PD22, p. 18).
It is apparent from the previous quotes that Participant D22 was very reflective about his practice. This sentiment is further expressed in what he said about how it is essential to function well within the team environment:

And that’s one thing we’ve talked about is how do we get… I don’t know maybe I’m jumping ahead a little bit… how do we get the value of actually functioning like a team… why does this work any better than referring outside for counselling services… both for the patient’s benefit and for us as professionals… that’s something we’ve always talked about… saying how is it different? Because even within the same building you can go weeks without seeing somebody (other team members) (PD22, p.19).

He also gave examples of a time when collaborative care was happening and then it wasn’t:

When I was brand new on the team some of the other physician groups and I was saying we were in four geographical sites to start with some of them had never worked with anybody like a social worker they really weren’t familiar with the role or a mental health counsellor and so at first when I was trying to build the practice I would actually go out to those site and sit with them and we’d talk about things and like little case reviews they’d say okay (Participant 5’s) coming out on Thursday at the end of the day and so I would bring a list of our common patients but then once we got busy we got a wait list and that kind of flew by the wayside… so I’m still convinced that’s a great potential there…(PD22, p.33).

Participant D22 clearly valued working with other members of the team and saw this as a primary agenda within his practice. He reported that any form of collaboration is important and while it may be challenging he saw it as a priority:
I do think case conferencing has a value so I’m going to keep kicking at that one until I can make it happen…I do think we need sometimes more of that even just hallway discussion because we tend to talk to people most who are closest geographically and so you have to be very intentional to then reach out to the people who are a little farther away and when we have multiple sites then that’s definitely going to be a challenge (PD22, p.34).

At the conclusion of the interview he expressed concerns again for needing more direction about the role:

They say mental health is an important program within family health teams…there is no clarity whatsoever on what we’re supposed to do…I think there’s a lot of similarity on what we do and luckily there’s tons of good discussion within the people who do the mental health role and most people are so kind and willing to share their work…(PD22, p.43).

**Empowering patients/clients.** Throughout the interview Participant D22 described his approach to working with patients/clients as action-oriented. He wanted to put the onus on the individual to make change and did so in a solution-focused manner. As previously quoted he asserted that it may not be helpful to keep patients/clients for the long term and is constantly looking at promoting a change agenda:

We’re going to talk with them (patients/clients) about what their goals for therapy are and we’ll contract with them starting at the first visit and then revisiting as we go…we talk about how we are going to do the work we do…(PD22, . 13)

He discussed how the work can be short-term with a bit of flexibility:
Some are 2 visits...some are 15 but on average we are seeing people in one go for 7 to 8 visits...the other beauty of his role...and I’m sure you’ve seen it too is we’re still here...so maybe I do a group of visits with somebody and things are going well, they’ve made some positive changes they are feeling comfortable...six months later if the wheels fall off they can come back in and so since we are connected to the family doctor and they’re used to being able to revisit their family doctor this becomes something they can understand (P, D22.14).

This statement mirrors an idea expressed earlier about how counselling within a family health team setting lends itself to a different model of counselling. It also further implies that short term counselling is not easily defined and in some cases might seem longer term than anticipated.

Also he felt it was important to build capacity:

I guess we’re trying to both address existing issues and also build resilience within mental health...so increasing peoples’ capacity to look after themselves so I think we have a pretty strengths based approach and a fairly skills based approach this isn’t a go to see your counsellor forever and ever approach cause we enjoy talking...(PD22, p.26).

Additionally participant D22 felt that inspiring hope is important:

We’re trying to come up with things we can work on say within an average 7 or 8 visits that are going to make a significant difference for that person so sometimes it’s building new skills for people and sometimes it’s refreshing them and their strengths and coping skills...giving them a sense of hope where none existed previously...(P5, p.27).
Empowering patients/clients is particularly important with regards to risk assessment. As Participant 5 suggested it is often a challenge to navigate the healthcare system in times of urgency and it became increasingly important to build the capacity of patients/clients:

Another thing I’ve identified is what if we identify a significant risk perhaps to themselves or even to somebody else and we try to facilitate having them assessed and perhaps admitted to hospital...that doesn’t always work particularly well either so you could have somebody with a significant degree of risk, call over to the emerg, send them with a letter and they’re back home and maybe it’s pressure for beds or something and we’re not doing that lightly if we’re going to be sending them to emerg…(PD22, p.46).

This suggests a challenge in supporting patients/clients when urgent situations arise. The final theme mentioned is one of having of role models who value collaborative care.

*Valuing collaborative care.* This final theme emerged throughout the interview. A final theme of valuing collaborative care was apparent from both his perspective and his account of interactions with other physicians and allied health professionals within the team. He began with an account of how he came to the position and his experience collaborating with a family physician who he feels pioneered the family health team model:

(In the past) I worked as a visiting social worker, I also worked as a case manager and a manager in that system and at one point when I was doing home visits in the community I came across one of the physicians who was working in the area and started to talk to her about some common patients that we had and developed a huge respect for her she’s a fabulous physician… (PD22, p.4).
It is interesting how his relationship with the family doctor started long before he joined the family health team. He reported that he first met this physician while he was employed in another position and was able to join her team when additional funding occurred. He reported that this particular physician was a good role model for collaborative care. Later in the interview when asked what made her a good role model he replied:

…so part of it is that she had worked with a social worker in her own practice…she hired the person out of her own pocket because she saw the value that it provided and then it freed her up to do the things that only she could do…in terms of people’s skills and knowledge there’s always going to be a lot of counselling done by family doctors but she could hive off a good chunk of that over to her social worker so by the time I came to the team she already loved the model…she created it on her own…you couldn’t ask for more than that…I also had a huge amount of respect for her clinical skill and acumen…she is one of those type A people and has 800 million projects on the go at all times (PD22, p.38).

Participant D22 also described how he felt respected within the larger team and was able to collaborate with others. He valued taking on a leadership role with regards to mental health and that he involves other mental healthcare providers in the process:

We’ve been fortunate so far that that’s the way things have worked so the strategic planning process has been a very collaborative process and the other social workers and I and our psychologist too, but he’s here half time so it’s a little harder for him, we kind of lead the mental health portion of the strategic planning so that there everybody would like our input they value our input…that works extremely well.
While mental health care appeared to be delegated to him and his other social work colleagues, he admitted to some challenges and potential for conflict of interest:

Instead of a community based board of directors our board up till now has consisted of all the physicians and the executive director...so really it’s been the physicians that have been steering the ship in terms of being the board of directors which is interesting because that does present some challenges too because there are no community...there are no patients on the board…there are no outside people or allied health people…that means decisions sometimes get made at the board of directors and they have to figure out how to communicate it to the rest of us...yeah so we are not always in the loop with everything that is going on (PD22, p.7).

Another challenge discussed had to do with what this participant called change fatigue:

We’ve encountered some change fatigue at times with the physician group so for instance one of the social workers and our psychologist started developing an attention deficit approach and saying here are some templates we can put in our computer record here are some things that we can do in terms of referrals and you know developing some programming around it and the physicians kind of went yeah okay…I’m tired…I don’t want anything new and so they really kind of hit a wall on that…timing wasn’t good (PD22, p.38).

This quote also points to an earlier idea about physicians steering the ship. Ultimately Participant D22 felt that interprofessional collaboration was valued and that due to the relatively small size of his family health team they were able to retain like-minded physicians who share this vision:
Because of the size we’re also able to be cautious about bringing on new physicians who had a similar philosophy about patient care...so (now) everybody’s starting with a lot of shared values and shared approaches and stuff like that whereas some of the big ones (Family Health Teams) started out with a hundred doctors and they are all over the place…multiple sites…they don’t even know each other...so we’ve felt a bit more like a team...so the challenge is as we grow and become another half again as big how do we keep that feeling? (PD22, p.10).

As previously indicated, some interesting events took place since the initial interview. In speaking with Participant D22 for a second time the researcher was informed that his particular family health team was going to increase in number of physicians but not in number of allied health professionals. What this meant is that while the patient roster will increase, the number of available counsellors/social workers will not. This concerned Participant D22 who stated that he will need to reevaluate his practice once more to ensure that he can accommodate the potential increase in patients/client referrals.

As previously stated, in addition to an increase in patient roster, Participant D22 reported that there has been a new council on primary care recently formed. He reported that social work/mental health counsellors were not included or consulted on the formation of this new council. He reported he is presently advocating for the social work role within this newly formed council. These two events reflected a continuing theme in primary care and family health teams where the mental health role is not represented during stakeholder meetings.
Participant Y79

Character sketch. Participant Y79 was a registered social worker and psychotherapist who had more than 30 years of experience in providing mental health support and psychotherapy. She also worked in private practice providing supervision and taught in academic settings. She reported she has worked at multiple family health team locations as both a mental health therapist and manager. The researcher first met Participant Y79 three years ago at a conference and shared with her ideas about this research. She has provided much insight into the family health team model as well as aided in networking with other mental health providers within the community.

First interview. The first interview was located within Participant Y79’s private office setting. She reported that she was soon retiring from her particular family health team and that she was interested in hearing more about the study. This particular interview occurred over the course of 1.5 hours and was more informal than those previously interviewed. The interview questions were given to her ahead of time and she stated she had a general idea of what the interview entailed. Participant 6 consented to having this interview included for purposes of the present research project.

Participant Y79 was contacted to organize a second meeting but at the time of writing the researcher was not able to get together for a second meeting due to conflicting schedules. See figure 12 for a current story map. The core message that was identified was a “challenging role that’s not for everyone” and the themes were “need to define role”, “need to advocate for role on the team”, and “culture of hierarchy and privilege”. This information is summarized in table 6.
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Figure 11. Final Story Map: Participant D22
Table 6

*Participant Y79*

Core message: Challenging role that is not for everyone

- Not a nice place to work
- You need to have an advanced level of education
- You need to be able to work with complex patient populations and psychological trauma

Theme 1: Need to define role

- Job title is inappropriate – should be referred to as mental health therapist
- We should be doing psychotherapy
- We should be dealing primarily with those with diagnosed mental health disorders

Theme 2: Need to advocate for role on the team

- We cannot see everyone, need to prioritize who we see
- Need to command respect and set limits with physicians
- We need to decide what are role is…not other members of the team
- Knowing one’s role and one’s scope of practice is the most important aspect of collaborative care

Theme 3: Culture of hierarchy and privilege

- Physician privilege
- Collaborative care decreases hierarchy
- Mental Health Therapists approach is non-linear
- Feels the Family Health Team model is ideal but this culture makes it difficult to utilize the model

**Final Core Messages and Themes:**

**Challenging role.** Throughout the interview Participant Y79 spoke about her role as one that is “not for everyone”. At the time of the interview she was nearing retirement and as she reflected back on her practice she felt like maybe it was not an ideal setting for her to work and that ultimately she felt she would benefit more, in terms of job satisfaction, from private practice.
I started working four days a week and then doing private practice in the evenings and I had been doing it all…private practice and [the family health team] and I was just…and [the family health team] was not a nice place for me to work, which I realized in retrospect (laughing) (PY79, p. 5)

She asserted that people who come to the position must have ample mental health experience and at least a graduate degree in the field:

I don’t know what you do at your family health team but at [her family health team] you have to have an MSW or an MA in counselling psychology and experience and you have to have five years post grad…so it’s not for beginners (PY79, p.7).

She further asserted that while her ideal would be to only work with persons with mild to moderate diagnosable illness in reality what she sees is a lot more complex:

Post-traumatic stress disorder, complex trauma is a major issue because there are no services…because trauma and PTSD treatment is longer term treatment…(PY79, p.14).

Her idea that mental health counsellors should only be dealing with mild to moderate mental illness suggests that complex cases would be better served outside of family health team settings. In her experience she reported that she often worked with more complex cases which in theory would require longer term services. This posed a conflict in case management.

Need to define role. A theme that was evident from the interview was the need to define the role of mental health counselling. She stated that she does not think that mental health counsellor is a good name for the position and that she felt a better title would be mental health
therapist. She felt that counselling was too vague a term and that people did not necessarily have a good idea of what counselling means.

Well first of all what’s the role…what exactly is the role…of the mental health counsellor…you know XXX came up with that name which I never agreed with him about that I say I joke with him you know what if somebody wants counselling why don’t you go to the bar (laughing) (Y79, p.7).

The person’s name she was referring to is omitted here so as to protect anonymity.

She also discussed the need to define the role because of the independence that comes with the role. She felt that in many cases the therapist is the only person fulfilling the role in a particular family health team and so it is necessary to have a well-defined role of what it is that counsellors do:

It’s independent in many ways…you’re the only person doing that job so I think the role ought to be defined…you know what does the province say ought to be the role of mental health therapists in family health teams because you can no longer say social workers in family health teams because there are social workers who do other things rather than mental health therapy…(Y79, p.7)

She felt the need to differentiate herself from social work and said while she’s proud of the profession she is embarrassed by her college’s lack of organization and need for constant accountability:

At the beginning of the year you fill it out right (her professional develop plan) it’s a requirement...well I don’t know...I wouldn’t have thought at the beginning of last year
that I would go to a bereavement workshop, which I attended and it was so good...(P. Y79, p.9).

The interview flowed along many interesting tangents, one which included a discussion on professional development opportunities. The interviewer decided to ask more about her idea of mental health therapist versus counsellor. She stated she felt the role should be of a mental health therapist because she felt “we ought to be doing psychotherapy” (P. Y79, p.12).

She also described the ideal function of her role as mental health therapist:

The physicians or nurse practitioners or other [allied health professionals] determine that a person is having problems in living and they might have mental health issues which should come first because that’s the position and that they would benefit from seeing a therapist so that begs all kinds of questions..if you are a mental health...let’s use XXX’s term... a mental health counsellor then are you not going to be doing mental health counselling first? Which means that you are not going to do marriage therapy cause there are other places you should be…unless it is in the context of a mental health issue…(PY79, p.12)

The idea Participant PY79 expressed is that the role of the mental health counsellor should primarily deal with persons with diagnosable mental illnesses. She felt that persons who are having adjustment issues or other life transitions or relationship issues would be better served not in the doctor’s office. She felt the need to prioritize the role to work primarily with mental health.

When asked to clarify that she meant therapists should only work patients with mental illness she replied:
Yeah...mild to moderate mental illness right...because that’s the definition...that there are places for severe mental illness and those are mental health clinics...case management services...so family health teams ought not to repeat any of those things because the intent is prevention (of mental illness) and early intervention...(PY79, p.12)

She referred to what she has read about her role as mental health counsellor while working in her family health team. In reality her practice was not as simple. She felt that the patient is a lot more complex and felt compelled to set limits about what she can and cannot do. She felt the role needs to be well defined so as to ensure appropriate referrals.

**Need to advocate for the role.** Another theme which was expressed is that of needing to advocate for the mental health therapy role and limits to the role. She felt the need to advocate in regards to the types of clients she sees. Recall earlier she discussed the increasing caseload and need to prioritize patients according to a mandate of treating patients with mild to moderate mental illness. She therefore felt that she cannot see everyone who is referred. When asked if she saw everyone? She responded:

Absolutely not...well we don’t...at [her family health team] boy are we terrorists (laughing) in the sense of you know first of all if somebody has private funding we check the address...if you’re living in [wealthy neighbourhood] you are not going to see us...I’m sorry if you can afford to live in a house...(laughing) (PY79, p.13).

She felt that it is important to prioritize her caseload so that she could be available first to those who do not have the financial ability to seek out mental health services. She was further asked about what she meant by “terrorists” and she replied:
Well because of the doctors…we would have triage from 2 to 4 Wednesday afternoons and everybody would drop in to discuss a case right…but they (the doctors) would make referrals and they wouldn’t write the referrals out and so we’d say “oh are they here this afternoon?” yeah…okay let’s go get them and so we’d call the doctor down and very good naturedly and they’d come to the door and go “oh am I in trouble? I’ve been called to the mental health meeting” and we’d laugh about that but we did hold them responsible and we’d say “tell us why you referred this person? What do you think we can do? Because we are really here to help the client”…message unstated…”we’re not really here to help you”…(PY79, p.15).

It is interesting to note how Participant Y79 referred to herself and her colleagues as terrorists when setting limits with her fellow physician colleagues. A discussion ensued on the isolation of mental health service teams where all mental health cases get referred solely to the counsellor with little physician involvement. In her case she discussed how she doesn’t allow other team members to defer responsibility to her role directly. This idea pointed to the need to share patient care and that all members should be responsible for mental health care, not just the mental health therapist. In her eyes advocating for the role meant setting limits with the team about the types of patients/clients she could see and times when other team members needed to step up and take more responsibility for patient mental health care.

Another point about advocating for the role is in who gets to define the role of mental health therapist. She felt that the role needed to be defined first by the professional who is practicing the role and not by other team members:
It’s not just our defined role but it’s also that our defined role ought to be defined by us first, rather than imposed, you know...what do you see yourself as doing? And you know what do you think is part of your role? (P Y79, p.23).

She asserted that the role of mental health therapist needed to be defined by the mental health therapist and that this is first and foremost an essential component. She also stated that knowing one’s role and one’s limits to the role is ultimately the most important part of the collaborative care process:

Because then the question is how will we collaborate? What can you do and how will I fit into that in the service of the patient...and so in order for us to do that ...I have to talk to you and you have to talk to me...(Y79, p.23)

She went on to say that if one is not doing this, then they are not truly collaborating and therefore are not fulfilling the function of a family health team.

**Culture of hierarchy and privilege.** A final theme which is evident from the interview was that of hierarchical systems and what Participant Y79 called “physician privilege”. The frankness with which participant Y79 spoke about this was evident and helped the researcher to understand her concept of privilege within the medical system. Participant Y79 felt that if team members were not collaborating they were contributing to a culture of hierarchy:

If you don’t talk to me because you’re nurse practitioners or doctors or residents or physicians or clerks or whatever…and you fill out a piece of paper because you’ve seen the patient and you hand it to me...we’re not having a conversation...we’re not having collaborative care...what we’re having is a hierarchy and that creates a culture and it’s not a personalized issue...it’s a cultural issue and so...so is there collaborative care? No! I
don’t care what anybody says…as long as that system where you’re not sitting having conversations and triaging and saying what will be the most helpful for the patient…(PY79, p.23)

She described how collaborative care can occur informally, in hallways or impromptu meetings. She also discussed how she and the other mental health therapists tried to initiate a formal process of collaborative care through weekly drop-in meetings with limited success: “here we are…all in one room…use our services…pop in…blah blah blah…and six years later you have to ask me…when’s the meeting again?” (PY79, p.24).

Participant Y79 was clearly frustrated in her attempts at promoting collaborative care and working in non-hierarchical relationships. When asked why she thought that mental health therapists were keen to collaborate more so than other members of the team she felt it was because of the nature of the field. She went on to compare the social work field with the medical field. She stated:

Well first of all we don’t think linearly about a patient...we think holistically…I teach medical students...first year medical students...they’ve just started their professional competencies and I can’t think of anywhere else where…well this is interesting…when you get to medical school they give you a backpack of a certain colour and you can identify them...oh that’s a first year medical student..I wonder what that says…what is the symbolism of that? And they have a white coat ceremony where they invite their parents and I presume they get a white coat and something or other…and it’s a big deal and there’s a reception...(P.Y79, p.25).
She asserted that counsellor training did not involve as much pomp and circumstance. She continued to discuss how medical school students are trained into power and privilege and much of it is internalized when they leave. She felt that by the time medical school students graduate they buy in to this idea of hierarchy and privilege. They have been convinced that they are experts. She concluded by sharing a vision of how to get out of an internalized expert role and use collaborative care:

If you’re actually doing collaborative care with the patient then you’re going to set aside a certain amount of time…you are going to build the relationship…you’re going to ask the patient what do you think is going on here…what do you fear is going on here…what do you think is most helpful?” (P Y79, p.27).

She described her decision to leave a previous position because she liked the idea of a family health team. She liked the idea of collaborating about patient care and about the patient being in charge of his/her care. Despite the challenges she has experienced throughout the years she ultimately felt that the model is ideal.

**Participant C33**

**Character sketch.** Participant C33 referred to her position as a mental health counsellor. This participant had 17 years of experience in providing counselling and psychotherapy services. She had worked in a variety of settings but in the past 6 years worked in a family health team setting. Participant C33 considered counselling to be a second career and stated she went back to university when her children were young to get a master’s degree in pastoral counselling. She had worked in a non-profit community agency providing counselling as well as in private practice. She found the work in private practice to be particularly isolating and so as a result decided to
<table>
<thead>
<tr>
<th>Professional background</th>
<th>Working with patients/clients</th>
<th>Working the others</th>
<th>Healthcare system</th>
</tr>
</thead>
<tbody>
<tr>
<td>(therapists not counsellors)</td>
<td>(interprofessional collaboration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Past experiences</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Various different locations, settings, outpatient mental health and family health teams</td>
<td>o Complex issues</td>
<td>o “Terrorists” need to advocate for your role</td>
<td>o Culture of healthcare</td>
</tr>
<tr>
<td>o supervision</td>
<td>o PTSD</td>
<td>o Some team members do not respect the role</td>
<td>o Doctors and privilege</td>
</tr>
<tr>
<td><strong>Present experiences</strong></td>
<td>o Need to define what’s the role in fhts</td>
<td>o Socioeconomic issues</td>
<td>o Unloading of patients (the end of the line)</td>
</tr>
<tr>
<td>o Defined by us, not imposed</td>
<td>o Need to screen for need</td>
<td>o Cannot see everyone</td>
<td>o Also there are situations where therapists feel valued and appreciated</td>
</tr>
<tr>
<td>o Everyone is doing things differently</td>
<td>o Focus on “what is treatable”</td>
<td>o CBT informed practice</td>
<td></td>
</tr>
<tr>
<td>o Need for standard practice</td>
<td>o Relationship is key</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Need to be able to work independently</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Not for beginners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Need for advanced skills in mh assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Future Intentions</strong></td>
<td>o Retire and continue with private practice</td>
<td>o Needs to focus more on therapeutic processes with clients/patients</td>
<td>o Need for more services for those with PTSD, complex trauma</td>
</tr>
<tr>
<td>o Continue with supervision consultation</td>
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</tbody>
</table>
First interview. The interview took place in her family health team office, which was located in a brand new building. The setting of the office building was in a small town that provided health services to surrounding rural areas. She described her practice setting as rural and discussed many challenges of working within a rural setting, particularly lack of physicians and increased demand for health services. Another interesting item was that she disclosed she was hired after a local factory closure and linked the increase in demand for counselling services to unemployment. She also identified addiction as a significant area of practice. Over the course of the interview she discussed various challenges. The beginning of the interview entailed going over the questions and explaining the research process. Participant C33 had no issue with any questions and consented to having the audio recorder playing during the meeting. The meeting lasted for approximately 90 minutes but it could have lasted much longer. The initial story map was conducted during the analysis phase (See figure 13). The story map was emailed to participant C33 ahead of a second meeting. As is noted there are some gaps in the future intentions section. The researcher was able to identify one core message and three themes from this interview. The core message is ‘new to the role’ and the themes were ‘interested in learning what others do”, “working with older adults”, and “working through past challenges”. The core message and themes were shared with participant C33 before the second meeting.

Feedback from second interview and final story map. The second meeting with participant C33 took place via telephone. The interview lasted approximately 30 minutes in length. Feedback received from this interview was that she felt it was a positive experience for her. She reported that she felt it was a great opportunity for her to reflect on her practice in the
**Figure 13. Initial Story Map: Participant C33**

<table>
<thead>
<tr>
<th>Professional Background</th>
<th>Working with clients</th>
<th>Working with others (Collaborative interprofessional care)</th>
<th>Health care system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past experiences</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Nonprofit counselling centre</td>
<td>o Trained in CBT</td>
<td>o Resistance from physicians – some not wanting the FHT</td>
<td>o Economic downturn</td>
</tr>
<tr>
<td>o Private practice</td>
<td>o Mindfulness</td>
<td>o Many challenges, interpersonal issues</td>
<td>o Factory closure</td>
</tr>
<tr>
<td>o Pastoral counselling, masters level</td>
<td></td>
<td>o Confusion regarding medical versus non-medical ways of helping</td>
<td>o Lack of area services for children and youth</td>
</tr>
<tr>
<td>o Second career</td>
<td></td>
<td>o Newer physicians accepting of model</td>
<td></td>
</tr>
<tr>
<td><strong>Present experiences</strong></td>
<td>o Independent role</td>
<td>o Concerned with outcomes</td>
<td></td>
</tr>
<tr>
<td>o Enjoyable role</td>
<td>o Uses mindfulness</td>
<td>o Grown acceptance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Various other modalities</td>
<td>o Valued for counselling role</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Supportive counselling</td>
<td>o Works with RN and Dietician</td>
<td>o Challenge for physicians</td>
</tr>
<tr>
<td></td>
<td>o Complex patients: long term relationships</td>
<td>o Collaborates with IHPs</td>
<td>o Lack of physicians in rural settings</td>
</tr>
<tr>
<td><strong>Future Intentions</strong></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
family health team. She also stated that it was a good opportunity for her to "process" some events that had taken place while working in her family health team. She also felt that the researcher’s feedback during the interview was encouraging to her. Together with the researcher, the story map was analyzed and some additions were made. Under the heading "professional role" she added that she hoped to train as a therapy supervisor to provide opportunity for students to practice within this setting. She did not like the term "future intentions" and laughed that she did not want anyone to "hold her to it". The heading was reframed more as an aspiration rather than an intention. She felt that this would perhaps be a better word. Under the "working with clients" column she added that she had training beyond CBT and wanted the researcher to know that she worked with clients from “where they were at” and did not impose a particular theoretical underpinning. When asked what other modalities she used, she stated she had been using mindfulness in the past as well as family of origin work and trauma therapy. It was suggested that perhaps her approach was more eclectic or integrative and she laughed stating that yes these were good words to add. It was confirmed that these were her intended words and they were added to the story map.

Under the “working with clients” column she also discussed future aspirations. She stated that she had recently explored professional development opportunities in addiction as she had identified this as a growing issue within her practice. She had sought further training in addiction counselling and family support counselling. This was added to her story map. We also discussed her work with other family health team members and the challenges she has faced when working with certain family physicians within her Family Health Team. She stated that while there has been great progress in her working relationships there was still room for continued improvement. She had aspirations for future improvement and would like additional support in this area. Under
“working with clients” she added the statements “still work to be done”, “wishing for physicians to refer more often”, and “more engagement from physicians”. Finally the researcher asked if any additions in the last column about the healthcare system were needed. Participant C33 reflected on the increasing demand placed on physicians due to her Family Health Team being in a rural setting. She wanted to add under “healthcare system” that in general more physicians are needed in her area and there was an overall need for more support. These were added to her story map. Finally the core message and themes were analyzed further. Participant C33 felt that this adequately depicted her experience and also added that since the first meeting she had expanded her practice to include older adults and was collaborating with the nurse practitioner on a group program for older adults. The core message from this participant is “new to the role”. The themes are “perspectives on counselling”, and “working through challenges”. See figure 14 for final story map. All additional content is displayed as underlined. The following is summarized in table 7.

<table>
<thead>
<tr>
<th>Table 7</th>
<th>Participant C33</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core message: New to the role</strong></td>
<td></td>
</tr>
<tr>
<td>• Wanting to hear what other counsellors are saying about the role</td>
<td></td>
</tr>
<tr>
<td>• Came to the role as a seasoned counsellor, but never worked within the family health team setting</td>
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<tr>
<td>• Had to develop the role on her own</td>
<td></td>
</tr>
<tr>
<td>• New Family Health Team created in her area due to demand for services due to economic downturn</td>
<td></td>
</tr>
<tr>
<td><strong>Theme 2: Perspectives on counselling</strong></td>
<td></td>
</tr>
<tr>
<td>• Eclectic and integrative approach</td>
<td></td>
</tr>
<tr>
<td>• Interested in collaborative relationships to facilitate counselling</td>
<td></td>
</tr>
<tr>
<td>• Work with older adults; supportive work</td>
<td></td>
</tr>
</tbody>
</table>
Longer term case management needed

Theme 3: Working through challenges

- Differences in style of practice between counselling and medical
- Some physicians resisted collaboration and ignored the role
- Increase demands placed on physicians interferes with collaborative care model
- Need for measurable outcomes; difficult to conceptualize in counselling

Final Core Messages and Themes

New to the role. All throughout the interview Participant C33 described being new to the role. Her main motivation for answering the research add was to be able to gain more information about what others have to say about their role and what it is that they do as counsellor within a family health team. At the beginning of the interview she wanted to know if she would be able to have a copy of the final product for her own information. She was assured this would be the case.

Despite having several years of experience working with the family health team she acknowledged that she had to develop the role on her own. She described how she came to the role:

I knew from working in town here that a family health team was coming...so I contacted them, said I would be interested, this was before there was advertising I knew they were just getting it set up, and they said send your resume and then they advertised I called and said I’d sent it in and they had me come in for an interview and I got the job (PC33, p.2).

While she had worked in the role for 6.5 years she said that the physical location is new. She described the recent change where they were co-located with the physicians:
Yes this building was actually the parking lot and it was an older building and when I first came they didn’t have room for the allied health professionals so we were at a different building...just around the corner that belongs to the hospital so they rented offices from them and the allied health professionals were in there so about two years ago in January the building was finished and we moved in together…everybody (PC33, p.3).

It is important to distinguish here that she felt she was not functioning within the ideal family health team model until approximately two years ago because she was not co-located with her family physicians until that point. Her experience is not unlike that of the other participants.

**Counselling perspectives.** Participant 7 discussed her approach to counselling. Having trained initially in cognitive behavioural therapy, she described her approach as eclectic and integrative. She had also trained in mindfulness and used the approach with clients. She also had an interest in family of origin work as well as trauma informed approaches. Recently she also had developed a keen interest in working with older adults and that has inspired a working relationship with the nurse practitioner within her family health team who specialized in working with geriatric populations:

I have a nurse practitioner...who works in geriatrics so she's referred people to me and out of the small part of my practice people that are older and maybe have chronic depression or anxiety or living in situations that they are not willing or they are not able to make changes so I'll see them maybe about once a month just to kind of review what are you doing...what can you change...can you change anything…how can we maybe get you involved more in the community...so you're not always at home...how can you access more services...(PC33, p.9).
She described her style of working with older adults as more of a case management approach. She stated that older adults often had additional chronic health conditions and so her role was to continue to promote self-management. In the end she felt that while she is not following a formalized treatment or therapy protocol she felt she plays a vital role on the team: “this is the one thing I try to talk to her about...what keeps her coming back...she's isolated herself and so the clinic has turned into her family…she's a frequent flyer…” (PC33, p.9).

With this particular client, participant C33 saw her role as not only as supportive but also as helping the older adult reduce her isolation and to promote community involvement. She was also responding to a need that she saw in her practice. She reflected on this support as not being a specific counselling technique or psychotherapy protocol but still seen as essential. She wondered if it was okay to use this role for longer term case management and sought out feedback from her administrator:

We had a meeting with our executive director about that...she thinks there is a role for that especially when it comes to seniors...so we discussed this and because it's not a big part of my practice and it's not like they're there forever because they either develop a health condition...or they can't come anymore or they end up in a nursing home...so it was decided that there is a role and there aren't a lot of other services in town so yeah it was okayed (PC33, p.10).

This relates to the idea that case management and longer-term supportive counselling can have a function within a family health team setting. Regular contact with some clients over a long period of time may prevent hospitalization because the mental health counsellor can refer to the physician should mild to moderate health concerns arise. In a sense the counselling session becomes an opportunity to assess physical health, indirectly through reporting any concerns to
the physician, and help the client/patient reduce social determinants that are compromising health.

**Working through past challenges.** Participant C33 described a lot of challenges in the role. These challenges pertained to working with other members of the family health team, mainly physicians. She described these challenges in terms of a difference in style of practice. She elaborated on these differences by giving an example of informed consent:

> I don't know...it doesn't matter as much to me now cause I've been here and I get that they've felt that's implied but when I first started here I didn't really like that idea and so we had meetings and talked around that issue and I said I just would be more comfortable having a consent form and explaining to them what counselling is and the limitations of privacy to them...they struggled with that...they didn't understand why I wanted to do that but they said okay...(laughing) so when the person first comes in I have the consent form and I explained to them what was private and what the limitations are to privacy (PC33, p.8).

In this quote she referred to the differing perspectives of family physicians compared to counsellors. She reported she felt this is a challenge when working in her role. She felt in this case that she needed to advocate for the client's right to confidentiality and wanted to introduce informed consent within her practice. While a physician works from the perspective of implied consent, meaning that when a person comes to see a family doctor they are automatically consenting by attending the medical appointment, a counsellor is operating under the principle of informed consent. In this situation Participant C33 was communicating that in the counselling practice consent needs to be informed, not implied.
In addition to differences in practice, Participant C33 described differences in valuing of the model. She described her experiences when she first came to the team:

When I first came some of the doctors were very on board and would talk and try to see how we were going to work together; others wouldn't talk to me and others wouldn't refer to me and six years later that's changed…they all talk to me now...(PC33, p.13).

A significant portion of the interview dealt with sharing stories about challenges faced along these lines. Participant C33 did not want to share her exact story for fear of becoming identified as a participant. The conversation was deleted from the transcript and not included in analysis but she gave consent to sharing, generally, what challenges she experienced. When asked why she felt that so much resistance occurred she offered the rationale that physicians are under a lot of pressure. This pressure had to do with she saw as increasing demands placed on physicians and the lack of resources available within the current healthcare system: “They have their practices that are bigger than normal practices and so they are exhausted” (PC33, p.15).

Another challenge she described is the differing perspective between the medical and non-medical or counselling perspective:

They see things in medical terms and they don't see things from the mental health perspective so for instance when it comes to running programs they want measurable outcomes...like if a person takes this sort of drug…they'll get better...but trying to explain what a mental health outcome is very difficult for some of them to accept and so they don't see the value of our programs so they're not really in favour of them (PC33, p.15).

This statement addresses one of the challenges that come from trying to understand the differing approaches to health.
Summary

The above chapter provided a detailed summary of results of all seven participants. A character sketch was provided in order to illustrate the various professional backgrounds that participants had when coming to the position of mental health counsellor. The research process of analyzing transcripts and mapping out the larger narrative of each participant was also described. This aided in examining differences in perspectives over time and the overall process of “storying” and “restorying” that takes place in narrative analysis. Based on the findings of these seven participants, meta-themes of professional background, professional practice and interprofessional collaborative care can be formed. The following chapter will include the results found across participants with explanation of a new model of mental health counselling within primary care settings.
<table>
<thead>
<tr>
<th>Professional Background</th>
<th>Working with clients</th>
<th>Working with others (Collaborative interprofessional care)</th>
<th>Health care system</th>
</tr>
</thead>
</table>
| **Past experiences**    | o Nonprofit counselling centre  
    o Private practice  
    o Pastoral counselling, masters level  
    o Second career | o Trained in CBT  
    o Mindfulness  
    o Family of origin work  
    o Trauma therapy  
    o Uses eclectic integrative approach | o Resistance from physicians – some not wanting the FHT  
    o Many challenges, interpersonal issues  
    o Confusion regarding medical versus non medical ways of helping  
    o Newer physicians accepting of model | o Economic downturn  
    o Factory closure  
    o Lack of area services for children and youth |
| **Present experiences** | o Independent role  
    o Enjoyable role | o Uses mindfulness  
    o Various other modalities  
    o Supportive counselling  
    o Complex patients: long term relationships | o Concerned with outcomes  
    o Grown acceptance  
    o Valued for counselling role  
    o Works with RN and Dietician  
    o Collaborates with IHPs | o Challenge for physicians  
    o Lack of physicians in rural settings  
    o Need for more psychiatry  
    o More youth services are available |
| **Future Intentions**    | Training as therapy supervisor  
    And having students working in family health team | Ongoing professional development  
    Addictions &family support | Still work to be done  
    Wish for physicians to refer more  
    More engagement | FHT needs more physicians  
    Need for more support |
Chapter Five: Across Participant Results

This chapter consists of a presentation of the across participant results. Similarities and differences of participants will be illustrated in relation to the main research question answered: How do the experiences of mental health counsellors working in family health teams help inform counselling practice, and how can understanding these experiences create a comprehensive understanding of mental health counselling within a family health team context. The following areas will be discussed: Perspectives on professional qualities and characteristics of mental health providers; definitions of the role; working with patients/clients; building relationships with family physicians; building relationships with other interprofessional healthcare providers; a comment on the healthcare system and recommendations for change.

The researcher chose the term “mental health counsellors” to describe those who provide mental health counselling services within a family health team setting. All participants were recruited and referred to as mental health counsellors to be consistent with previous research conducted within southern Ontario (Kates, Crustolo, Ferrar & Nicoloau, 2002). When interviewing participants it became apparent that there were differing labels given by the mental health professionals themselves as well as by the family health teams. While some were familiar with the job title, others referred to themselves as either social workers or mental health therapists or counsellors. Within the participant sample, three called themselves social workers, two referred to themselves as therapists and two referred to themselves as counsellors. All participants agreed that the role they performed was a counselling role, three stated they felt at times they provided psychotherapy services; two stated that they felt that psychotherapy could not occur within the professional role because it went beyond allowable resources. One person felt that the term sounded too elitist and felt that counsellor was a better description of the role.
The following section will present the across participant results with particular attention paid to answering the research question. The following sections are divided into areas of professional background, professional practice, and working with others in the family health team (interprofessional practice) and, in addition, larger category called healthcare systemic factors will be presented. Also recommendations from participants are discussed.

What further becomes apparent from the analysis of participant narratives is that four meta-themes exist. These meta-themes are in areas of professional background, professional practice, and interprofessional collaboration. All of these areas take place within a larger context. In this case the health care system. In order for mental health counselling to be defined, it is important for providers to have awareness of all areas. Also it is apparent that each meta-theme overlaps with another and therefore they can influence each other. Analysis of the across participant narratives yields the following model, pictured here in Figure 15.

Figure 15: Mental Health Counselling in Family Health Teams
The following analysis describes where areas overlap.

**Professional Background: Qualities of Counsellors in Family Health Teams**

**Advanced skill.** All seven participants believed that in order to perform the role of counselling in a family health team you need to have advanced clinical skill. The reasons for having advanced skill were varied. For example: Participant P30 felt that she would like to continue to develop skills. She felt that she needed to continue her education to advance her counselling skills. She had a BSW and would like to apply for either an MSW or an MA program in counselling psychology. In her current position as addictions counsellor she was not required to have a master’s degree.

Participant B89 felt that advanced skill is needed. She was adamant that due to complex issues and the need to advocate for patient care, that the position was not for a new grad:

I don’t think you ever get used to complex care…so I think you need to have some experience to kind of know community resources…how to advocate for the client with the physician…with the physicians pushing back because I don’t see this as a hierarchy…I see this as a lateral…but maybe a new grad would see this as a hierarchy…(PB89, p.17).

Participant B89 also felt that the type of work required good assessment skills, to be able to navigate crisis situations and know how to respond to patient safety.

Participant Y79 felt that a high level of skill is also required:

At (our) family health team you have to have an MSW or an MA and experience…but you have to have five years of experience post grad…so it’s not for beginners (PY79, p.7).
Wanting a change in setting. Another common element was that all seven participants interviewed wanted a change in their practice setting. Some came into the role serendipitously and others sought out the role because they heard that a new family health team was being developed in their area. All participants reported that they were attracted to the model of practice: collaborative interprofessional mental health care.

Participant X17 shared reasons why she came to work in primary care. She came to the position following the downsizing of her department. She described why she chose to come to a family health team:

I didn't want to work in the hospital, which was mostly discharge planning...what I wanted to do was therapy and you know that's my sort of thing…and I looked around the world and of all the places it seemed to kind of encapsulate the kind of work that I wanted to do and enough pay...I chose this place because it had very amenable bosses and it was extremely close to home (PX17, p.6).

In this quote, participant X17 referred to kind of work she wanted to do. She spoke about her value of the collaborative care model and also discussed the type of work she wanted to do within mental health care. Her description of amenable bosses spoke to her need to be valued within her work environment.

Similarly, participant B89 shared why she decided to change jobs:

it just wasn't stimulating enough and I had my eyes on a position in (place)...I really started focusing on mental health which led to me leaving a big institution for primary care (PB89, p.2).

Participant C33 stated that she felt her previous work in private practice was too isolating and so when she heard there was a family health team coming to her area she was interested:
I enjoyed parts of private practice, but I found it very isolating and you have to do a lot of different things that I found that I didn't enjoy like the financial part of it all that sort of thing...just it wasn't for me...so I knew from working in town here that a family health team was coming here so I contacted them and said I would be interested... (PC33, p.2).

**Job satisfaction.** Despite challenges, the majority of participants reported increase job satisfaction. Five out of the seven participants loved their work and the setting of providing counselling within a family health team. Two participants felt that looking back over the time they have spent in primary care they are not sure if they would have taken on the role knowing what they know now about the nature of the position.

Participant B89’s feelings about the role seem to suggest she has experienced challenges:

Choosing it (the role) later on in life was actually kind of wise…I can’t imagine young grads doing this kind of work...I kind of feel a little concerned…I pay for supervision…and I meet with peer consultation every two weeks...and I learned everyday …knowing what I know now I wouldn’t have chosen primary care (P B89, p.16).

Similarly, Participant Y79 expresses her feelings about the role:

(Her family health team) was not a nice place for me to work…which I realized in retrospect (laughing) (P Y79, p.5).

This participant was also at the end of her career working in family health teams and has decided to retire to her private practice. It is interesting to note that the two participants who have retired expressed challenges with the role. Job satisfaction might not necessarily mean that there were not challenges with the role, but that those who have participated were able to find satisfaction despite challenges.

**Assert and advocate for role.** Participant Y79 felt that the role needed to be better defined. Building on its complexity she asked the government for criteria:
It’s not for beginners...it’s independent in many ways...you’re the only person doing the job right?...so I think you know the role ought to be defined...you know what the province say ought to be the role of mental health therapists in family health teams? (PY79, p.8).

Working with Patients/Clients: Defining Approach

All seven participants were able to describe and define their counselling practice. There existed varying opinions as to what this practice looked like. All participants felt that counselling within a family health team model called for brief approaches. Participant X17 notes that he is able to “turn over” patients/clients in on average 7 to 8 sessions. He described his general approach:

we would decide after meeting the person and getting to know them a bit…getting to understand their reason for coming to see us we talk about different therapy modalities focused...is it cognitive behavioral therapy so we're going to talk to them about what their goals for therapy are and we'll contract with them starting at the first visit and then revisiting as we go and them talk about how are going to do the work that we did...we did do a little statistical analysis and saw on average we see people 7 or 8 visits as an average...(PD22,p.13).

As for what it is that counsellors do when working with patients/clients, the responses were also varied. While everyone stated that they felt their role was to counsel patients it was difficult to articulate a common definition of counselling across participants. It is interesting to note that counselling was seen as separate from psychotherapy. Participant X17 revealed her impressions:

I guess if your work is driven by formulation...if you are resourcing somebody or if you know you are connecting them to services or just deescalating a crisis you know you are
not necessarily working from the conceptualization of the problematic right?...so if you have a formulation then it becomes psychotherapy (PX17, p.24).

Participant X17 revealed that she often used psychotherapeutic approaches in working with patients/clients but that often there are other presenting issues which surface and can derail the process. She discussed the need to conduct a three-session assessment and if this could not occur then she could not complete an accurate conceptualization of the problem. She felt that failure to do so can lead the professional relationship to be less therapeutic and more focused on case management.

and sometimes it's like you know our first session has a formulation and what I often find is that it is quite hard to do the first session so we give it three sessions to do that and what I think happens is that if you can't get to that then what you are doing is case management (PX17, p.24).

In these responses it was clear that she felt there is a clear difference within the counselling relationship where she uses therapeutic approaches versus case management. It is unclear as to whether psychotherapy is a part of counselling or is completely separate. Participant B89 stated she felt that the two are separate. While she was trained in various psychotherapeutic modalities, she felt what she does at her family health team is counselling and not psychotherapy:

I think it's going to be more and more counselling than psychotherapy because we don't have the resources to see everyone and it's not as in-depth...looking more present focused in the counselling field as opposed to long term issues...that's my opinion (PB89, p.12).

**Complex issues.** The term “complex” was used by all 7 participants. Some participants related complex issues to historical psychological trauma while others stated that complex issues were related to other chronic conditions which were resistant to treatment. When asked to clarify what was meant by complex cases participant X17 responded:
It’s like you’re holding them (the clients) and providing them with a safe environment so they can come back to you to deal with things as they come up…that’s complex mental health…and we have those with very longstanding kind of problem…so chronic…(PX17, p.61).

She also elaborated on how these clients tended to have more than one mental disorder and that their presentation was not a first episode. She also related complex patients to having a trauma history.

Participant B89 also used the word complex on several occasions. She reflected on her first impressions of working in a family health team:

I couldn’t believe the amount of complex cases, families, everyone was different, every person had obviously a unique story but it was pretty overwhelming for me I would say the first couple of years (PB89, p.3).

Similar to Participant X17 she reflected on her relationship working with complex clients:

In a lot of ways we carry these people…not forever but for years because their counselling may have stopped…they have moved on…but in two years there is a crisis or something’s triggered…a loss…so they call again…(PB89, p.4)

Both Participant X17 and B89 implied that they were a constant within the process of patient care.

Participant A24 discussed the challenges of working with complex clients:

In general I’m being pushed…so I don’t think it’s something that is out of my scope but it might be something that I haven’t done a lot of so I think you need a certain type of person in this role…someone whose willing to go…uhhhh you know I really need to read more about this…that’s the one thing that keeps me going and allows me I think to expand my role so I guess here I feel my role is pushed a little bit more than it would be
somewhere else but then my personality is okay with that and again it’s something that
I’m totally unable to do I’ll declare that (PA24, p.20).

In the above statement, Participant A24 described how she is being challenged constantly in her
work to learn more about how to best help complex patients/clients. She felt okay with this and
felt attracted to the challenges she faced each day. She also knew when to set limits with others
on the team in regards to scope of practice.

**Trauma counselling.** All seven participants identified the need for additional services
particularly in dealing with historical trauma. While some participants came to the position
having worked with survivors of trauma, others came to the position and sought additional
training:

what I have found is that I often get referred for depression anxiety but I keep my own
numbers…I’d say about 30% of the clients I see have a history of childhood
trauma…so that was real piece…an eye-opener for me really that was so prevalent in the
population of people I was seeing...so I’ve had to kind of go out and get extra training on
that…(PA24, p.6).

Participant A24 shared an interesting point that what had originally been referred to her as
a mental health disorder issue (i.e. depression or anxiety) was actually more complex and was
largely due to historical trauma.

**Brief goal-oriented techniques versus long term support.** Counselling relationships
were either categorized as brief solution-focused or longer term case management. Participants
felt that there were two categories of care, those who could benefit from a short term approach
which would focus on specific change and those who were not ready to work on specific changes
but required longer term support to help prevent the need for hospitalization. Further to longer
term relationships there were also complex patients and patients requiring longer term trauma
informed care. All participants felt that these approaches were necessary except for Participant D22 who argued for only taking on short-term clients. He questioned if ongoing longer term relationships were helpful:

That was a discussion too when I started because some of the physicians thought you know maybe there is some of the people you know who are constantly chaotic and problem focused and just take sort of a case management role which might mean seeing them forever…but it’s a little harder to say how do we know that that’s helping? How do we show that that’s made any difference at all? Cause there’s a very good chance that it hasn’t (PD22, p.15).

Here Participant D22 argued for all counselling to be short term and goal directed.

**Building Relationships with the Family Health Team**

**Acknowledging differences.** All participants acknowledged differences between the way they practice and the way the team practices. For example, Participant X17 felt that there was a disconnection in how mental health care is conceptualized:

You know they believe the best model is going to be like a doctor or nurse…and I’m going to see you like two times…you know what I mean…for this many visits…and my notes are going to be two lines…and you know why can’t I do intakes right away? (snapping her fingers) because I’m only going to be seeing them for two times…I mean there’s no conceptualization of the problematic that might involve longer term…(PX17, p.3).

In this quotation, Participant X17 expressed frustration with the medical model of care and how it does not always coincide with a mental health counselling model of care. She referred to the
increasingly complex patients who require longer term services and are not always ‘fixable’ in a few sessions.

There were also differences in how the counsellor practiced in comparison to other family health team members. For example both Participant P30 and B89 referred to the “luxury of time”. What they implied is that compared to other team members, mental health counsellors had more time to spend during individual appointments. Participant P30 discussed this difference:

A lot of IHP’s are basically there so when a patient goes to their doctor and they have these issues, the doctor has maybe 10, 20, 30 minutes depending upon the appointment, and if something comes up then they don’t have the detailed time to spend with them…so I like having the luxury of time to spend with patients where doctors are quick in and out kind of thing…(PP30, p.8).

Similarly, Participant B89 also shared this sentiment.

I think we have less continuity of care and we have more service providers seeing our clients so I think that’s the other thing when people come to see me I will always say to them you know I am going to be your consistent mental health therapist or person and I’m not going to rush you…you’re not going to have 15 minutes…you’re going to have 50 minutes...so these are all the luxuries that we have working in the field …(PB89, p.9).

In addition to discussing the luxury of time she also referred to how she was the constant service provider for counselling. While patients in her family health team may have seen more than one doctor or nurse she will be the only counsellor working with a particular client. This helped to ensure some continuity of care.

Finally, Participant C33 also described differences in approach:

They see things in medical terms and they don’t see things from a mental health perspective for instance when it comes to running programs they want measurable
outcomes…like if a person takes this sort of drug…they’ll get better…but trying to explain what a mental health outcome is very different for some of them to accept and so they don’t see the value of our programs…so they’re not really in favour of them (PC33, p. 15).

In the above statement, Participant C33 felt that differences in approaches to patient care often created a misunderstanding and devaluing of the mental health approach. In her interview she discussed many challenges when working with physicians in her team and often these challenges stemmed from a basic difference in approach to working with patients/clients.

Communicating the mental health counsellor role. Among the interviews there was a need expressed that other professionals within the family health team were often not exactly sure what mental health counsellors do. It then becomes important for participants to be able to understand the role and communicate it to other members of the team. For example, Participant X17 felt that there was a large disconnect between what expectations are placed upon her and what it is that she could actually do:

There’s a great understanding of the primary care system so and though they want us to be a part of it they don’t quite know what it is that we do and they want us to put their framework on it (PX17, p.3).

Participant X17 felt that the current research may in some way serve as a means of communicating an understanding of mental health counselling to inform others on the team about what it is that counsellors do.

For participant B89 communicating the role was very much a part of the process of counselling in family health teams. She stated that it was very important to know where one’s limitations lie and one’s scope of practice.

I think you know when you work in primary care you have to know what your limits are because based on the nature of our model our scope of practice is pushed to the
boundaries as it is…so people sitting in this chair really have to know what their scope of practice is…I say no…and again I have a luxury of other colleagues (PB89, p.14).

Participant A24 felt that communicating the role occurred over time and those other members of the team, particularly physicians, needed time to be able to develop trust. To her, communicating the role occurred by allowing time for other team members to get to know what she was all about and to gain acceptance.

It was interesting…when I first came…the physicians were not used to working with social work…they were older physicians and I think they hadn’t been exposed to that in their own training so quite honestly when I first came here I wasn’t doing much of anything (laughing) because honestly they didn’t know what to refer to me…I was very mindful of the fact that physicians had relationships with the patients for decades…and so in some cases I didn’t want to come in and look like I was taking over the mental health care…finally I got to the point where they would say “go ahead”…they had to learn to trust a little bit (PA24, p.3).

**Promoting collaborative interprofessional care.** All participants felt that they were the main promoters of collaborative care within their family health team. Often they were the ones to initiate a collaborative care agenda. For example, participant D22 discussed how he was intentional about collaboration:

Well they’re (the family physicians) on both floors but there are doctors right around the corner from me…I see them more often…I see them around the coffee and stuff…some of the other ones even though they are down a floor I might pop down and I don’t catch them and I go okay the heck with it I’ll just write a note within the computer system…I could go…it I wasn’t intentional about seeking them out I could go months without seeing them which is funny…(PD22, p.19).
Participant Y79 also felt that she and her colleagues were the main initiators of collaborative care. She referred to her role as “terrorist” in the plight to promote collaborative care. When asked to clarify what she meant by this she replies:

Well because of the doctors…we would have triage from 2 to 4 and everyone would drop in to discuss a case…but they would make referrals and they wouldn’t write the referrals out and so we’d say “oh are you here this afternoon”…”oh am I in trouble”…(PY79, p.15).

In this statement she reflected on the constant struggle she has had getting physicians involved in collaborative care and she has felt a bit like a terrorist in order to set limits regarding appropriate referrals.

**Systemic Issues**

Systemic issues refer to the healthcare context. The health care system is presently experiencing financial issues, which is illustrated by the wage freeze of ministry of Ontario healthcare workers and cutbacks to family physicians and nurses. The role of mental health counsellor has not received a wage increase in the past five years. The following are some of the systemic issues addressed among participants.

**Funding model.** Multiple participants referred to what they called the funding model of family health teams. Some participants felt that the current funding model made it difficult for family health teams to function in a collaborative way. For example Participant D22 shared his impressions of why collaborative care may not happen:

Our own physicians...can they do that? [bill for talking to counsellors] So let’s say we want to do case consultation and say okay every once in a while we are going to sit down...
and talk about our risky complex cases and stuff like that...can they bill for that? (PD22, p.32).

When asked to clarify he stated that there was extended health billing and he felt physicians could be motivated still by the old billing model.

Participant X17 also referred to the funding model when discussing complex patients. Her feeling is that the model does not adequately compensate Family Health Teams for complex patients:

And so the funding equation isn’t always seamless or reflect what the needs are...family health teams are having to take on complex patients...you know that’s part of the funding model is that they are having to take on whatever new patients from these complex referrals...(PX17, p. 22).

Here she expressed her frustration with the increase in complex patients and difficulties with keeping up with demanding caseload. She felt that when family physicians are required to take complex cases this reflects her ability to provide mental health care.

Hierarchical model. There was a discrepancy between those who share the belief that a family health team is still a hierarchy and those that do not feel one existed. For example Participant P30 felt motivated to participate in the current study as she felt it will bring a voice to the profession. She said:

Typically we don’t have a voice...even though we are a team and there’s no I in team, there’s still a huge hierarchy and power imbalances that exist within the team and I thought that wow if I can be part of some research to kind of speak to that…(PP30, p.3).

Participant P30 was excited about being a part of this research because she felt more research from the perspective of those who provide the mental health service would help shed light on
what it was like to work in a family health team. She saw her role in this research project as giving voice to the profession. Similarly, Participant Y79 discussed the hierarchy in family health teams:

If you don’t talk to me because you’re nurse practitioners or doctors or residents or physicians or clerks or whatever...and you fill out a piece of paper because you’ve seen the patient...that you hand to me…we’re not having a conversation...we’re not having collaborative care...what we’re having is a hierarchy...(PY79, p.23).

This statement addressed the issue of hierarchy in the practice of delegating or referring a client for mental health support without any follow up or input. She additionally stated that if professionals were not collaborating then they were working in “silos” (PY79, p.23) where service providers can become isolated and overburdened.

The issue of feeling overburdened is also expressed in Participant X10’s statement:

Easily you know you have to kind of struggle until the burden is completely obvious and then maybe you will get somebody...I feel we are being asked to do a great deal increasingly (P X10, p.22)...

This statement reflected the idea of delegation of all mental health issues to the counselling role. Ideally every team member should be responsible for providing mental health care. Participant X10’s reflection suggested that she is alone in taking on the high demand for services.

However not all participants felt that a hierarchy exists. For example Participant B89 felt that there is not a hierarchy. When it was reflected to her that at times it feels like there is a hierarchy she responded:

Well that’s one perception...or that’s how you set things up pretty early…anyone coming into a job like this is going to be tested...so it’s important to set boundaries (PB89, p.17)
She felt that the idea that the doctor has the most power is an internalized problem and that mental health counsellors need to take on a leadership role so as not to perpetuate a hierarchy. Additionally, Participant A24 did not feel there is a hierarchy. She reflected on the current challenges physicians face:

Here I’d say I feel very respected…I don’t feel there is a hierarchy in a sense but that’s almost a role hierarchy because they (the physicians) have certain role obligations legislated to them that I don’t have…I don’t feel that when we work together there is a hierarchy…the hierarchy is imposed by the powers that be…by the legislation (PA24, p.34).

Participant U40 also said that no hierarchy exists and that those who have felt this are inexperienced:

I think you need to advocate for a client with the physician when the physician’s pushing back because I don’t see this as a hierarchy I see this as a lateral [relationships]…but maybe a new grad might see it as a hierarchy (PU40, p.17).

She went on to suggest that anyone coming to work in a family health team would be tested:

Pretty inappropriate referrals so it’s really important to set boundaries and be clear on your role…your scope of practice…who you… are you willing to deviate from the code of ethics and sign a script?…are you going to work overtime?…are you going to do a lot of charting at home?…what are you going to do to take care of yourself?…(PU40, p.17).

She said that this was not a hierarchy issue, it was a self-care issue and that it is essential that counsellors have gone through the process of learning how to set boundaries within others about their scope of practice.

Participant A24 made an interesting point about different forms of hierarchy. She did not feel that others in the team have more say. She felt that they have more of an obligation. This
point referred to the idea that in a Family Health Team model the family physician is the one most responsible for patient care and liability would first extend to the physician.

Need for research. All seven participants felt that more research is needed from the perspective of mental health care providers in family health teams. All seven had a keen interest in this project because they felt that they could somehow contribute their knowledge to add to the research. There were varying ideas about what that research should look like. Participant X17 and D22 stated that more research was needed on the professional role whereas Participant A24 felt that research was needed on perceptions of privacy legislation and how they differ between social workers/counsellors and other medical professionals. Participant P30 shared that she wanted to be part of the present research to have a voice. She shared that within the family health team model her role typically does not have much of a voice in that major decisions are made by administration and family physicians. She stated:

Typically we don’t have a voice...having a bit of a social work background… and even though we are a team and there’s no I in team there’s a huge hierarchy and power imbalances that exist within the team and I thought that wow if I can be a part of some research to kind of speak to that…(P P30, p.3).

Participant X17 shared that she would like to put together a proposal to develop a toolkit, which would describe how to provide mental health services within family health teams. She was hesitant to because she felt that maybe it is not her role to do so or that perhaps she had too much to deal with as it was and she may not have the time to take on this additional task. She was enthusiastic about research on the topic, whatever it may be:

Yes...Yes...Yes… I want that…you know research…however it’s conceived provides some backup for the position but also I would be interested in something like the toolkits being produced…that would be a very practical thing…which is not going to come from
your thesis… but why not you know I mean I would do it…I would put in a proposal but at this point I would then have to then supervise somebody…and why should my FHT do that…you know like who am I to do it right? (PX17, p.4).

Both participant A24 and D22 shared past research experience within the area of collaborative interprofessional care. Participant A24 shared that she was involved in a research project during her master’s degree on what she refers to as “primary healthcare multidisciplinary research” (PA24, p.2).

Participant D22 shared his past experiences with research in multidisciplinary teams:

it was what my master’s thesis was on as well…way back when…which was in a hospital setting about peoples’ perceptions of the roles of physicians, social workers and nurses and so I had 40 people try to define their own role in each of these groups and to define each others’ role and then try to see the similarity there was between their self-definition of role and their definitions of each others’ (PD22, p.3).

He had an additional research question of needing to understand the role of the mental health counsellor/social worker within family health teams. He also expressed concerns that if the role is something that others can do and was not defined as something specialized to counselling or social work then it may jeopardize the role in general:

It is an area of social work and one of things I’ve found through my literature review when I did my master’s thesis was social work and hospitals and in other places too … in a time like this is a kind of vulnerable position…in times of financial cutbacks because there was…in my thesis…say in the hospitals umm there was nothing that social workers said they did that either nurses and or doctors didn’t also say they did…so there was no unique role…(PD22, p.35).
This sentiment indicated an issue regarding role definition and the perception of what it is that counsellors and social workers do in the role. Participant D22 was reflecting on a readily experienced sentiment that anyone could do the counselling role and that it is not a subspecialty.

Participant Y79 talked about the present research project and the journey the researcher will partake in through qualitative interviews. She gave good advice on what the researcher could expect from the process:

When you’re doing this kind of research you are actually working backwards…you have an idea and you have a question but then you have the conversations and out of those conversation you code…you’re listening for things…you’re listening for themes (PY79, p.33).

Summary

Chapter five presented across participant findings from the qualitative interviews of 7 participants. While there existed differing perspectives on what is mental health counselling and experiences of providing counselling in Family Health teams, there was also a consensus on a variety of topics. All participants reflected on the experiences of mental health counselling, that is what is needed in order to successfully take on this role within a family health team setting. In addition, all participants were able to identify and conceptualize how they worked with patients/clients and the approaches to counselling they take given the present workplace setting. In regards to collaborative interprofessional care, all participants felt that in order to build relationships with other team members it was important to first acknowledge differences. A main concern was that mental health counsellors needed to understand their role within the family health team in order to communicate and advocate for the role. Also mental health counsellors value collaborative interprofessional care and all participants gave examples of how they
approach other team members. Another consensus was that often mental health counsellors were the ones to initiate collaboration in the service of advocating for their clients/patients. Challenges of interprofessional care were also discussed. For example, a variety of systemic issues were identified such as the current funding model, a culture of hierarchy and privilege among those in the medical community, and the increasing demand and complexity of referrals.

Recommendations include a need for research on best practices for both mental health counselling as well as collaborative interprofessional mental health care. In order for mental health counselling to be properly defined, it becomes essential for all four themes to be taken into consideration in order to facilitate care. It is also apparent that each area can help or hinder the counselling process. Participant results indicate that mental health counselling is comprised of the professional role, working with patient/clients, and working with others or the interprofessional team. All of this occurs within a larger context that is the healthcare system. It has been the experiences of these participants that in order to have successful mental health counselling all areas need to be developed. This is a non-linear process that in all participants' case has occurred over time. The following chapter will discuss these findings in relation to the current literature.
Chapter Six: Discussion & Conclusion

This chapter discusses the meta-themes distilled from the within participants and across participants results. These meta-themes are related to the participants’ story maps as outlined in chapter 4. For the purpose of this discussion they will be outlined under the headings professional background, professional practice, interprofessional collaboration, and systemic perspectives. The first three meta-themes are overlapping concepts that help create the construct of mental health counselling in family health teams. These three areas are enveloped within the fourth meta-theme or context of a larger provincial healthcare system. The original story map, which was outlined in chapter 4 details the narratives of the four distinct meta-themes. From the interview data it becomes apparent that an understanding of mental health counselling occurred overtime and counsellors moved from areas of having skill and knowing, to not knowing and tension/confusion and then to knowing again and understanding their practice within the larger context. The stories that have unfolded are of both facilitators and barriers to providing mental health counselling services. What is quite apparent is that all participants have taken great care in trying to understand and identify what it is that they do within the context of the Family Health Team setting. All participants told stories involving appreciation of lifelong learning regarding the role. Results indicated that while challenges exist, the position yields great potential to be fulfilling from a job satisfaction perspective. This progression of understanding and clarity that has ebbed and flowed has also yielded expectations about the future and recommendations for future development of mental health services within family health team models.

The purpose of this research was to examine the narratives of the experiences of mental health counselling within family health teams and specifically how mental health counsellors come to understand their counselling practice within an interdisciplinary team. The data from the
current study suggests that while participants can clearly articulate what it is that they do, there exist varying perspectives among the following themes of professional background; professional role; and collaborative interprofessional care. Also, while most participants feel satisfied with their work they are able to describe for times when challenges exist. This section will detail a discussion on the emerging meta-themes and where they converge and diverge with the current literature. While the literature points to the importance of the role of mental health care in family health teams there are no current accounts of lived experiences of counsellors within this setting. This section aims to relate the literature back to participants' experience. An integrative model of mental health counselling in family health teams (pictured below in Figure 16) is proposed with additional implications for practice.

![Figure 16: Mental health counselling model in family health teams: practical implications](image)

Figure 16: Mental health counselling model in family health teams: practical implications
Professional Background

Professional background is defined as the knowledge required to successfully function within the role of mental health counsellor in a family health team setting. This section discusses the impact of professional background on mental health counselling in family health teams. Results from the current study imply that advanced clinical skill and well-developed professional background are not the only essential requirements to take on the role. The professional background of participants in the current study, while varied, is one that has adapted and changed throughout their time working in family health teams. The following section will discuss these changes. Data from the study indicated that professional background and experience can certainly influence practice, but additional knowledge is needed about the types of clients/patients as well as how to best function within a collaborative team.

The results from the current study illustrate the need for counsellors to have advanced skill. This is so as to be able to have a clear understanding of how to best support patients, but also to be able to effectively communicate one's scope of practice to other team members. Counsellors who require constant supervision or guidance in regards to case conceptualization or when case management or advocacy is needed will soon discover that they are lacking.

The results from the current study indicate that those who come to the position, while having a lot of years of experience do not necessarily have a high level of experience working in primary care or a family health team setting. This is largely due to the fact that family health teams have only been around since 2005 (Government of Ontario, 2015). Also the profession of counselling has undergone some changes in the province. Since beginning this research Ontario has experienced regulation changes with the proclamation of the Psychotherapy act on April 1, 2015 (CRPO, 2015). While the role of counselling has not yet been regulated, many counsellors
use psychotherapeutic models within their everyday practice and will need to register should they also want to practice psychotherapy.

A guide to interdisciplinary teams’ roles and responsibilities, published by the Ministry of Health and Long Term Care of Ontario (2005) has articulated guidelines for each role except for that of a mental health counsellor. They recommended that any member of the team who has acquired a specialization in the area could be permitted to take on a mental health and addiction treatment capacity within the team. These could consist of social workers, social service workers, addictions counsellors, psychologists, psychiatrists, and nurses. They did not articulate a role of mental health counsellor, despite the fact that there are currently individuals who work in Family Health Teams whose job title is mental health counsellor.

This fact is consistent with findings from the current study. Participants interviewed came from various educational backgrounds with expertise in differing areas. As previously mentioned, of the 7 participants, 6 had educational backgrounds in social work. One of the 6 had an additional background in nursing. Another 1 of the 6 had an additional background in addiction. One participant had an educational background in counselling and pastoral counselling.

In terms of prior years of experience in mental health and counselling out of the 7 participants only 1 stated that they wanted to obtain graduate education and training in social work and/or counselling, while the rest had a master’s degree. Six reported many years of experience, ranging from 14 to 30 + years.

The participants’ work experience prior to coming to work in a Family Health Team also varied. Of the 7 participants, 3 had previously worked in hospital, 1 had worked in a government agency, 1 had worked in a community agency and hospital, 1 had worked in an outpatient psychiatric setting and 1 had been in private practice. From the data it is apparent that the professional background of these participants has varied considerably. With varying professional
backgrounds come varying areas of expertise in the field. For example, while all had training and experience in counselling, two had additional experience in trauma counselling and one also worked with a child and youth population. This addresses the overlap between professional background and counselling practice. Professional background, previous professional experience and setting will all contribute to the type of counselling practice which the individual develops.

The fact that providers come to the role from varying backgrounds, with varying experiences in service provision, and with limited information given to them in the form of policies or recommendations for best practices may contribute to confusion. It is clear that this is a recipe for a challenging position. While some participants felt inspired by the challenge and have adapted quite enthusiastically to the role, others at times have felt overwhelmed.

Kates’ (2008) report on a specific family health team setting may help to explain this confusion. Kates’ (2008) suggested that providers need to be flexible in their role. He states that they need to be willing to see clients with a wide variety of issues and know when to refer on. He further asserts that care should be provided in the "style" of the family doctor. One might assume that if the provider is not familiar with the setting or the practice of the family physician that this will influence their adjustment. Data obtained from the current research echoes this point. Participants reported that their approach needed to be compatible with the family doctor's.

All participants told stories of a new and novel role in mental health care. They were attracted to the position because they felt hopeful about the Family Health Team model and excited about the opportunity to be a part of developing this new position. They shared stories of enthusiasm about being "in-the-right-place-at-the-right-time" during the creation of their team. Two participants shared that they were interested in the position because of prior research experiences. One was interested in the practice because she wanted a change in setting. One
chose the position after being downsized by her previous employer. Two chose the position because of its flexibility and goodness of fit with current life situation.

Data from the narratives obtained indicated that the majority of participants felt largely satisfied with their work. This was also expressed in earlier research on the role of counsellors in general practice (Sibbald, Addington, Hall, Brenneman, & Obe, 1996). In Sibbald et al.'s (1996) study, both counsellors and general practitioners were generally satisfied with the service and described some benefits and few disadvantages. Kates et al. (2002) also reported satisfaction with all stakeholders, including mental health counsellors. The fact that most of the participants reported feeling some satisfaction in their work suggests potential for development of the role.

While the study’s findings echo the literature on challenges in working within the setting, it goes beyond to articulate how counsellors’ have overcome these challenges. While all participants felt that there existed challenges with their work they were largely able to overcome these challenges through a greater understanding of the larger context of primary care and family health teams. Participants reported that they were inspired by the work they do with patients/clients as well as were able to work effectively in interprofessional teams. This addressed a larger issue of meaning making and working despite differences.

Job satisfaction was largely influenced by the types of patients/clients seen and by the challenges posed. Participants reported that they felt challenged by their work and that they were often seeing patients with a variety of complex issues. This challenge contributed to participants feeling a sense of professional growth over time. This sentiment is also echoed in the literature. For example, a study by Kates, Crustolo, and Mach (2008) indicated that the types of clients/patients seen in primary care settings were similar to those in hospital settings. The outcome of the study also suggested that severe and persistent mental illness was also seen in primary care settings. It appears that current participants were challenged by the complex patients.
they counselled, versus feeling overwhelmed. This pointed to the personality attributes needed to be a mental health counsellor in family health team settings. That is they enjoy to be challenged.

The findings of the current study cannot be generalized to assume that all mental health counsellors in Ontario report high job satisfaction; however, the majority of participants in the current study reported good levels of job satisfaction. This may largely be due to the successful integration of mental health counselling within the family health team setting. While challenges existed, participants were able to make sense of these situations and overcome these challenges over time. Largely this was due to the clientele served. This sentiment is also apparent in a study by Gazzola and Smith (2007) who concluded that while counsellors’ roles were diverse the participants surveyed were generally satisfied with their chosen profession.

On the other hand, participants were able to report times when they were dissatisfied with the role. These times were largely due to the impact of both working with clients/patients as well as with the interprofessional team. With respect to working with patients/clients decreased job satisfaction was related to feeling overwhelmed by the increase in referrals and inability to meet patient needs because of lack of available resources. One participant reported that they were able to address this issue through the creation of an urgent appointment service that usually gave priority to children and youth or clients at risk of self-harm, suicide. A similar American dissertation on the experiences of counsellors working in integrative primary behavioural health settings further elaborated on challenges experienced (Gersh, 2008). Gersh's (2008) participants identified challenges as adapting to working within the culture of a medical model, differing treatment approaches among medical providers, and feelings of isolation at time. Several participants in the study also spoke of feeling isolated, especially when new to the position.
Professional Practice

From the proposed framework, the meta-theme, professional counselling practice is developed based on the skills that are acquired through training and professional background experience as well as the types of patients / clients that are referred. Professional practice is also influenced by interprofessional practice. Professional practice can be facilitated by other members of the team, for example through the use of collaborative care practices or else can be impacted by challenges experienced.

Data from the current study indicated that most counselling or psychotherapeutic approaches used need to be "evidenced based". This was consistent with an understanding of the practice setting as the evidenced based movement is rooted in medical science (Trinder, 2000). This study indicated that participants value the practice of the model, as well as evidence based practice. It is also interesting to note the degree to which setting influences practice. Most participants who came to the position had already developed skills in evidenced based practice such as Cognitive Behaviour Therapy or Mindfulness Based Stress Reduction. Participants also stated that while they came to the position with evidenced based skill, they sought out additional training based upon information from the setting as well as from the clients/patients themselves.

Some participants in the current study reported concerns with their practice being evidenced-based. They pointed to the need for formal evaluation criteria so as to ensure that what they are doing is effective. Other research has also pointed towards the importance for evidenced based outcomes. A review of past randomized controlled trials revealed that there was no conclusive evidence as to whether or not counselling in primary care yields positive health outcomes (Rowland et al., 2000). Some initial results found that counselling showed a modest yet significant improvement and the data is considered tentative. The authors of this study indicated
the need for more research (Rowland et al., 2000). Participants from the current study also reported this need.

Participants reported that practice could be either short-term or long-term depending upon the client’s/patient's presenting issues. They differentiated between short-term brief approaches versus longer-term case management approaches. All participants pointed to the experience of having complex patients. They also reported that psychological trauma is a frequent core issue among patients. The increasing number of complex patients posed a concern regarding necessary treatment. This concern is that complex patients may not receive the needed treatment should only brief models be imposed (Kates, McPherson-Doe & George, 2011).

Also, there existed an apparent relationship between the concept of complex patients and trauma patients. While not all complex patients had trauma histories persons with trauma histories may present as more complex and require specialized trauma services. While many participants have developed capacity in trauma treatment, either previously coming to the role or in the aftermath of taking on the position, it is unclear if trauma care is the responsibility of the family health team or if this should be referred outside of the practice setting.

In the current study, most participants reported that services they provide should be largely brief approaches and that the current climate necessitated this. This was consistent with Firth's (2010) article on mental health counselling in primary care settings. Firth (2010) cited that the view that “brief models” are appropriate is a potential barrier to care. Firth (2010) asserted that the counsellors should be the one to determine the best approach for clients/patients and that while brief approaches may be helpful for some there are others who may require more long-term interventions. Firth's (2010) research also suggested that counsellors also need to monitor themselves through regulation and ongoing training and professional development. The current research suggested that participants interviewed are all endeavoring in this manner.
In regards to psychological trauma and post-traumatic stress disorder (PTSD) in primary care, one study suggested that those with diagnosed PTSD use healthcare resources more than non-PTSD patients (Stein, McQuaid, Pedrelli, Lenox, & McCahill, 2000). It therefore becomes necessary for case conceptualization to include assessment of historical trauma. The current research found that often patients were referred for assessment and treatment of a mental health disorder and that the disorder was simply conceptualized as major depression without the knowledge of a trauma history. Additional research normalized this occurrence. McQuaid, Pedrelli, McCahill, and Stein, (2001) also discovered that among those they interviewed with trauma histories, not all developed a diagnosis of PTSD, or other related mental health disorders. They found that the majority of individuals did not develop mental health issues. What they did discover was that those who did develop mental health disorders were not that of PTSD but of major depression. This research might help to explain why so many patients referred for depression have trauma histories. It does not answer the question of whether patients require trauma specific therapy and if so should it happen in a family health team?

Six out of the 7 participants felt that at times longer-term case management was a part of counselling practice. One participant felt that there was no evidence to suggest that longer-term relationships were beneficial to clients. Another participant argued that longer-term relationships can prevent clients from going to hospital or emergency room visits. They also differentiated between counselling and psychotherapy. Participants felt that what they were practicing was counselling and that psychotherapy provided more of an in depth or long term relationship. They reported that when they did longer-term work they were doing case-management rather than any therapeutic work. One participant even felt that the role was too burdened by referrals to be able to provide the specialized psychotherapy services that were needed. An analysis of this data indicated that practice with patients/clients in family health teams would entail all three areas;
counselling, psychotherapy, and case management, and both short-term and longer term for each area. With this idea in mind it also reflected participants’ views that they are doing a great amount for patients in terms of types of services provided. Also participants felt that, in consultation with the counsellors/providers, family health teams need to better define and prioritize services. What this means is that they needed to determine what they can do and what they needed to delegate to others whether it be other team members or to decide this was beyond the mandate for primary care and needs to be referred to other community agencies or specialized settings like hospitals.

Participants in this study came from a variety of professional backgrounds such as social work, nursing, and counselling. The majority of the participants in this current study came from social work professional background. The Ministry of Health and Long Term Care of Ontario (2005) has provided some guidelines for the role of social workers within a family health team model. These guidelines include providing assessment and social work diagnosis, treatment or management, education and advocacy, and referrals and collaboration. Assessment referred to employing a psychosocial assessment framework to add to the existing biomedical conceptualization. The document did not elaborate on what is meant by diagnosis. Treatment consisted of counselling and psychotherapy approaches. The Ministry did not elaborate on what modalities should be used or differentiate between counselling and psychotherapy approaches. Education referred to the provision of psychoeducation of mental health and mental illness including strategies for prevention. Advocacy referred to helping patients navigate certain governmental and non-governmental systems in order to obtain resources.

The current study indicated that counselling practice within family health teams is quite demanding. These demands can impact those who choose to work within the setting. One study on the psychological impact of managing complex client referrals stated the importance of
acknowledging psychological pressures associated with client work (Rizq et al., 2010). Acknowledgement is important so as to prevent burnout or compassion fatigue (Rizq et al., 2010). Participants from the present study reported that they are all involved in ongoing peer support and regularly connect with other members in the field. Also the province’s Association of Family Health Teams of Ontario (AFTO) also provided opportunities for support though professional conferences.

**Interprofessional collaborative practice**

Data obtained from participant narratives indicated that the position could be either one that is quite isolating or else one that is full of daily ongoing interaction. In a sense the role was an independent one, but can be isolating relative to the team environment. It is therefore interpreted that those providers who can clearly articulate their professional expertise, as well as identify the types of patients/clients they can help, will achieve perceived success in the position. Also facilitators and barriers associated with the team can also hinder success in the position. For example, participants who required support from team members but are not able to access this support may be prevented from providing the appropriate services to patients. Support may not be available for a variety of reasons, such as lack of interest from physicians, lack of time, and lack of resources. This idea was also indicated in Davidson's (2000) article addressing the challenges of the role of counselling in primary care. This author recommended that successful care occurs when optimal conditions are met. These conditions were the personal qualities of counsellors, stress levels related to the job, job satisfaction and the perceived support for the process.

The current study speaks to the inherent philosophical and ontological differences between medically and non-medically trained professionals. Findings indicate that
interprofessional practice may also be constrained due to the differences in medical versus non-medical approaches. Providers of mental health counselling services were largely from non-medical professional backgrounds. This may contribute to a culture clash of sorts. Gunn and Blount (2009) also illustrated some of the differences that impact practice. These are listed as differing treatment philosophies, action versus process orientation, and use of differing professional language and standards regarding confidentiality (Gunn & Blount, 2009). The current research also pointed to these issues. For example, participants reported that their treatment philosophies are largely strengths based and their approach emphasizes self-regulation on the part of the patient. This may be facilitated or constrained depending upon the approach of other team members. This pointed to a larger implication that mental health counsellors need to be aware of both medical and non-medical approaches to mental health and wellness.

Gunn and Blount's (2009) second barrier, namely, action versus process orientation was also displayed in the current study. For example, participants reported that they felt compelled by patients and other team members that they are "doing something". This was largely due to the evidenced-based or outcome oriented approach to care. Stories from participants demonstrated the need to either create recommendations for best practices, for example in the form of "toolkits" or to receive recommendations for best practices in the form of government reports or policies. Participants felt the need to legitimize their role. They often reported feeling that patients were coming to them looking for them to "do something". While participants were interested in evidenced-based outcome oriented practice, they often reported feeling pressured by the action orientation approach.

The third barrier of different professional languages was apparent throughout the data. For example in the current study, it is difficult to ascertain appropriate language when describing what to call persons who receive the mental health counselling service. At the conclusion of this
study it is still unclear if individuals should be referred to as patients because they are considered patients of the family doctor or if they are clients because they are clients of the non-medical participants. Participants also scrambled to quickly understand 'med speak' a term used in Gunn and Blount's (2009) article. Some of them were already familiar with the medical language having working within other healthcare settings. The interview transcripts displayed evidence of how language is used interchangeably, going back and forth between using medical and non-medical language when describing their work. The particular words that were identified throughout were patient/client, counselling/treatment, mental health disorder/psychosocial issues, and so forth. The authors stated that if providers are not aware of these differences they may also be impeding communication with other providers (Gunn & Blount, 2009).

The final barrier is that regarding confidentiality. Gunn and Blount (2009) reported that the medical culture is a lot more lenient in corresponding with other members about patients. This was in contrast to mental health professionals who are very strict about confidentiality. The current study yielded participant narratives that illustrated this point. For example, one participant stated that there was an issue in her office where non-medical staff was reading confidential information and that changes had to be made so as to protect patient privacy. All narratives suggested that other team members were more comfortable with impromptu hallway consultations than formal meetings however it is unclear at this point if it is due to issues with leniency in confidentiality or as a result of extraneous factors.

Chong, Aslani, and Chen's (2013) study on interprofessional collaboration in mental health also described additional barriers to care. These findings were reported as attitudes and beliefs about collaboration, meaning those who did not value collaboration often did not seek out collaborative working relationships. The current study yielded narratives of positive and negative attitudes towards interprofessional collaboration. Many participants felt that other team members
valued their role. Some participants told stories of having to gain entry or of being ignored. One participant said it took about 6 months for other team members to understand and respect the role. Another participant said that it took many years. One participant claimed that she is still trying to assert and advocate for the role and that it is an everyday battle.

Participants in the current research shared stories of collaborative interprofessional care and particularly how to obtain good working relationships with other team members. One participant found that ensuring a good fit in relationship beforehand is necessary. She only decided to come to the position because she had a good idea that she would be able to work collaboratively with her team before even starting to work with patients/clients. Other participants who do not have the option of getting to know the team chose to take a more flexible approach. The stories shared by participants about recommendations for interprofessional care are consistent with the literature. One study on recommendations for successful interprofessional collaboration defined a good working relationship as one where mental health counsellors are willing to be flexible and willing to collaborate with other professions all while maintaining an attitude of openness and understanding (Airken & Curtis, 2004). Participants from the current study demonstrated willingness for collaboration through stories about impromptu hall meetings or regularly sharing information with other team members when it is in the service of promoting patient care. All participants from the current research said they valued the interprofessional model and were committed to understanding the biomedical model of care while sharing their own models with the team.

The data also pointed to the need for providers to inform others of their professional expertise and what participants have referred to as scope of practice. Participants expressed frustration when other team members did not understand what it is that they can do within the
team. They further asserted that there were times when they felt mental health services were "offloaded" onto them.

The findings from the current study suggested that there exists a need for mental health counsellors to continue to advocate and communicate their role. This idea suggests that there continues to be a lack of role clarity among family health team members and in particular regarding the role of mental health counsellors. Therefore collaboration is necessarily and one goal would be to promote communication. This can be done through ongoing collaboration with other members of the family health team. England and Lester's (2007) study, on defining mental health counselling in primary care, also called for more communication of the professional role. It was suggested that in order to enhance communication all stakeholders should be involved (team members, patients, providers) when determining needed skills, until a consensus is achieved. They proposed a flat lined style of communication. The present study indicated narratives of this style of communication; however, at times participants have reported feeling that their scope is influenced or challenged by both the type of patients/clients that are seen as well as the demands placed on them by other team members, in most cases the family physician.

**Systemic issues**

Systemic issues pertain to the overarching context within which the three meta-themes are held. This last meta-theme includes two potential issues that may directly and indirectly impact mental health counselling within family health team settings. These two issues are the funding model and the hierarchy of professions in the current model.

Since beginning this research the governmental priority regarding family health teams has changed, from one promoting the validity of the model to questioning its worth. The larger systemic narrative of family health teams has largely in the past been that they are new and improved ways of providing ongoing care to patients. Narratives of participants also reflected this
change in perceptions of government priorities. Past experiences of participants showed that they were given free rein over their position to determine what they would need in order to function within their capacity on the team. Many participants reported that they were excited about the opportunity to participate in something truly innovative. But over time participants reported narrative experiences that involved challenges; challenges that one participant had called "change fatigue".

The reality of the current healthcare system has seriously impacted the family health team's ability to provide collaborative interprofessional mental health care. Participants frequently reported that they experienced a high volume of referrals and that they often had to be "creative" with how they managed caseloads. One participant stated that it became essential to collaborate with other community agencies so as to bridge patients to services outside of the family health team. Another participant claimed that in the rural setting where her Family Health Team was located, shortage of physicians contributed to family health team doctors having other responsibilities outside of the medical clinic. This too impeded collaborative care. The narratives of this study mirrored findings from a qualitative case study on mental health care in family health teams (Mulvale, Danner & Pasic, 2008). The authors’ (Mulvale et al, 2008) study of contextual factors that had impeded interprofessional mental health care made reference to the current lack of stable funding for mental health providers in Ontario.

Participants in this study reported concerns with current lack of resources. They further reported issues pertaining to wages as well as lack of staff to support increasing demand for services. Another issue that was detailed was that of the current funding model and its implications for interprofessional practice. Participants felt that physicians simply were not financially motivated to engage in interprofessional collaboration. One participant pointed out that physicians cannot bill for the time used for consultation with counsellors and so therefore
they may be tempted to just refer patients but not require any kind of follow up. Participants further indicated that they were the ones engaging in consultation and often would be the first to initiate collaboration in the service of patient care. The research from the literature also mirrored this idea.

A recent review of the funding models of Family health teams in Ontario has revealed ample concerns (Petch & Tepper, 2012). The first set back was that while more Ontario residents have a family doctor, many cannot see their doctor within a timely manner. Increased wait times have also been cited as a result of this new model. Also while family physicians were recruiting more patients, these patients are wealthier and in good health. Furthermore many physicians were not providing evening and weekend services. These setbacks occurred within the context of a funding model where family physicians were paid per patient and not per visit. The authors (Petch & Tepper, 2012) address the issue that under capitulation models family physicians are not motivated to see their patients because they will be paid for them anyway. Also physicians may be give preference for less complex patients who are requiring less care.

The healthcare system needs to be aware of this phenomena and to address it accordingly either by providing additional funding for services in order to keep up with increasing demand or else to allow for billable time for physicians to collaborate with other professionals in the team.

Hierarchical Structures. This study yielded a new idea with regards to the concept of hierarchical structures in medical models. Narratives suggest that hierarchies occur however one's internalization of hierarchy can serve as a barrier to collaboration. This idea of hierarchy has been discussed in a recent research review on family health team interprofessional collaboration. A recent Canadian article by Gocan, Laplant and Woodend (2014) discussed the phenomena of hierarchy within family health teams. The authors reviewed 95 articles on collaborative interprofessional care practices in Ontario and found evidence that those who perceived
hierarchies within family health teams felt negative effects. These dynamics were seen as a deterrent to collaborative care. The authors discuss the need for flat line organizational structures and physician leadership to minimize hierarchical structures and promote interprofessional collaboration.

The current findings were consistent with another research article on professional culture in the context of family health team interprofessional collaboration that discusses the concept of physician dominance (Beales, Walji, Paposhak, & Austin, 2011). The authors discussed this concept, stating that many physicians still adhere to old hierarchical structures and that this can influence team settings. This qualitative research study found that certain tensions exist within family health team environments and that structures are needed such as established collaborative processes, and clearly articulated scope of practice, skills, and authority, clarification of roles and responsibilities and opportunity to develop team relationships in order to reduce these tensions.

The current study illustrated the need for acknowledgment of hierarchical issues. While not all participants felt that the hierarchy was problematic, the reality is that within a Family Health Team, the physician is the one most legally responsible for health care and that the allied health professionals (in this case mental health counsellors) play a consultative role. Family physicians in the end have what one participant referred to as ultimate "veto power".

**Integrative model of mental health counselling in family health teams**

There currently is a lack of information on best practices in counselling and collaborative mental health care from the perspectives of mental health counsellors. The narratives from the current study demonstrated instances of confusion about how best to practice collaborative interprofessional health care and also how best to provide mental health services to patients in this healthcare setting. This research serves to add to the process of developing best practices for
mental health counsellors who work in family health teams. As indicated, mental health counsellors have had to create an understanding of their role and responsibilities with minimal guidance and therefore one can draw upon these experiences in the hope of sharing this information to future newcomers to the role.

The narratives of 7 participants presently employed as mental health counsellors in family health teams in southern Ontario yielded meta-themes of professional background, professional practice and interprofessional collaboration which are overlapping constructs that come together to influence an understanding of how mental health counselling can function in family health teams. Findings also point to the larger context of the current healthcare system in Ontario with attention paid to the hierarchical nature of the medical model and potential funding barriers which impact collaborative care. Participant stories yielded both positive and negative narratives of providing mental health counselling services within this setting. This sentiment is consistent with shifting governmental priorities, from one that idealizes and praises the family health team model to one that seriously challenges its capacity to provide best practices and outcomes. An integrative model of mental health counselling is proposed, one that addresses the question of what affects mental health counselling in family health teams. Professional background, professional practice, and interprofessional collaboration all play a role within the context of the healthcare system in influencing how mental health counselling is performed. The final section will conclude research findings and provide recommendations to practitioners, administrators and government.

**Conclusion and Future Recommendations**

Mental health counselling in family health teams is a complex role. In order for mental health providers to fully understand best practices in family health teams it is essential to fully
understand one's professional background and scope of practice, the type of patients one will serve and the best ways in which to serve them, as well as how to employ the assistance or assist other professionals in enhancing mental health care. It is also important to have a greater sense of the organizational and governmental climate. The current study illustrated how mental health counsellors have come to understand their role within this context. This understanding has been a gradual process that has unfolded over time. Narratives from the current study displayed themes, which held much success yet many challenges and barriers still needing to be addressed and overcome. This section includes a summary of the research, limitations of the research, implications of the study, future directions for research and a final concluding reflection.

**Summary of the research**

There is limited research on counselling in family health teams from the perspective of counsellor's themselves. While there is ample research on the vision of primary mental health care and collaboration within interprofessional teams, there is limited attention paid to the professional experiences of counselling from mental health counsellors themselves; the individuals who are the main stakeholders in providing mental health services within a primary care setting. These individuals are the key implementers of the policies that have been written. The current research question is what is mental health counselling in family health teams and how does collaborative interprofessional care impact counselling? The researcher has attempted to answer these questions by using a qualitative research method called narrative inquiry. The conceptual framework of this research project is social constructivism. The researcher interviewed 7 mental health counsellors about their experiences working in family health teams and with other health professionals in the service of providing collaborative mental health care. A narrative analysis of the interviews, which included the use of a story map as a research tool,
yielded within and across participant results. While each participant’s response varied, there was consistency among understanding of the counselling process and definition of the counselling role within the setting. Also, all participants were able to express their understanding of collaborative interprofessional mental health care and the facilitators and barriers to providing patient care. This understanding contributed to an integrative model of mental health counselling in family health teams. In order to fully define mental health counselling it is important to take into account the interrelationship between three meta-themes of professional background, professional practice and interprofessional collaboration. These three meta-themes influence one another and in turn are influenced by a larger context that is the current healthcare system.

Limitations

The first limitation is with sampling. While this study does provide some insight into the day-to-day experiences of mental health counsellors working within family health teams more participants are needed to generate more perspectives. Therefore replicating this study to include a larger sample of participants might help to thicken the description of what it is like to provide services within this setting. The use of a qualitative research paradigm, in the present narrative inquiry, has afforded the opportunity to examine the nuances of mental health counselling in family health teams as understood by 7 counsellors. The goal of the present study was to gain increased knowledge and insight about the intersections of mental health counselling in family health teams.

The second limitation is with geographical location. All participants came from family health teams from a variety of locations in Southern Ontario. Some participants came from rural settings while others from more urban setting. Additional research is needed with more settings, for example examining the issues faced in urban versus rural settings. Also, the geographical area
could be extended to include other parts of Ontario, not just the GTA, Hamilton/Halton/Niagara and Southwest Corridor.

A third limitation is with limited diversity in professional background. While the 7 participants from this study were all counsellors, they were from various professional backgrounds. Of the 7 participants, 5 identified as social workers and 2 identified as counsellors. Among the social workers 2 identified as therapists and other identified as clinical social workers. While all participants identified as mental health counsellor as a main professional group, they also indicated a subgroup affiliation. Additional research is needed involving the various subgroups in order to examine differences in perspectives of services providers.

A final limitation of this study is the potential for researcher bias. As noted in Chapter 1 the conceptual framework is social constructivism. This framework helped inform the researcher's assumptions of how knowledge is shared. While the writer acknowledges the active co-construction of knowledge and the implied meaning of the stories shared certain precautions were taken so as to guard against researcher bias. While the fact that researcher also has role as mental health counsellor may have helped with development of rapport and ease of conversational engagement, the researcher is also mindful of the certain assumptions held about the role before interviewing participants. The use of multiple informants from different geographical locations, validity checking with participants and a triangulation of research methods by using a field journal, interview data analysis, and participant feedback helped to guard against researcher bias.

**Implications**

There are several implications from the present study. One of the main implications is of the need for ongoing discussion and research about best practices for providing mental health
counselling in family health teams. Additional resources are needed to develop the capacity of mental health service providers to ensure best practices. Resources to develop capacity should include the development and implementation of supervision and peer support models. Models for supervision of counsellors as well as peer support programs are needed to help with the development of the role and take into account not only counselling practice but an understanding of team-based dynamics and interprofessional collaboration. In the past counsellors who had taken on the role were seen as experienced in mental health care and therefore support was not seen as a priority. Given that the role is new it is important to have ongoing supervision until best practices can be better defined on all levels.

Another implication is that more direction is needed on best practices for collaborative interprofessional mental health care. Also more direction on physician engagement in interprofessional teams and encouragement of family doctors to become more involved in mental health care in family practice. Members of family health teams need to come together to discuss each other’s roles and how they can work with the patient to ensure best practices.

A third implication is related to the increasing demands experienced within family health team models and pressure from the province to meet patient needs in a cost-effective manner. The findings from the current study illustrate the complexity of patients’ needs. Very often the patient presents with a mental health issue and upon further examination their need extends beyond the limits of primary care. Further training of all healthcare professionals is needed in mental health care to take into consideration the increased complexity of patients. Specifically this research has identified need for further support to develop capacity for providing trauma services.

An additional implication is associated with the enthusiasm and values shared in regards to the family health team model. The current research has identified an area of interest in
developing the capacity of mental health counsellors and the need to increase these providers’
voice and presence within Family Health Teams. The findings show that providers care a great
deal about their practice and are interested in ongoing development of best practices. Further
research is needed that will continue to involve mental health counsellors as key informants on
best practices.

Recommendations

A primary recommendation for future research would be to replicate the study with a
larger group of participants from other regions in Ontario and Canada. Also replication of the
study to look at differences between experiences of mental health counsellors in urban and rural
settings would be beneficial.

Another aspect that needs further investigation is to examine the experiences of those
receiving mental health counselling services, the patients/clients themselves. It would be
beneficial to know if patients/clients are satisfied with the present level of mental health services
in family health teams and inquire as to what recommendations patients/clients have.

Additionally a practical manual on mental health counselling in family health teams needs
to be developed. What has been referred to in this research as a “Mental Health Toolkit” could be
created to help inform best practices. Additionally policy to build on the current
recommendations for best practices of mental health counselling in family health teams in
Ontario should be developed.

Additional research on collaborative interprofessional mental health care in Family Teams
is needed. Particularly, these recommendations should include best practices for collaboration
and developing collaborative teams within the current environment is needed.
**Recommendations for education and training.** Based on results from the current study there are various recommendations for education on the topic of mental health in primary care or family health team settings. Academic courses in both medical and counsellor/social work training programs can be created to include providing mental health services within the setting. Training for medical doctors could include separate courses on mental health counselling which can include both directive and non-directive counselling skills, establishing rapport with patients with mental illness, promoting patient self-management, culturally safe practices, and the use of brief and evidence based trauma-informed interventions. Similarly for counselling and social work training, coursework on the above topics is also needed with additional emphasis on case formulation and supervision models.

**Recommendations to mental health counsellors.** Based on results from the current study it is important for both new and seasoned mental health counsellors to be aware of the dynamics of interprofessional teams. It is also important for counsellors to be aware of the complexities of patients coming to speak to their doctor about a mental health concern. It is also necessary that counsellors are aware of the high demand and the necessary case management skills needed to help navigate the high volume of referrals. Self-care then becomes an important priority in order to prevent burnout and compassion fatigue.

**Recommendations to administrators.** Administrators need to be aware of the dynamics of family health teams and the barriers to collaboration within teams. More advocacy is needed for the role of mental health counselling and to help to communicate a counsellors scope of practice to other team members. Administrators must continue to serve as a liaison between physicians and mental health counsellors. Administrators need to advocate for additional funding for supervision of mental health counsellors.
**Recommendations to government.** More policy is needed that incorporate best practices of mental health services within family health teams. Government needs to be aware of some of the barriers that currently exist to collaboration such as capitated funding and lack of resources for sufficient numbers of mental health counsellors. The Ministry of Health and Long Term Care could provide resources for mental health counsellors to develop a best practices manual with particular attention paid to supervision issues and counselling practice within the family health team context.

**Summary**

This chapter provided a discussion of the intersections of mental health counselling in family health settings from the perspectives of 7 mental health counsellors presently employed within the field. It also provided a conclusion of the topic with discussion of limitations and recommendations for future study, practice and policy.

While all counsellors shared unique and insightful stories of providing services within the setting there existed a unifying experience of what it is like to provide counselling within this particular setting. And, while most of the participants’ experiences mirrored that of current literature on the topic, their existed some new and novel ideas about providing services within this setting. For example, the suggestion that complex patients require specialized care within primary settings identifies a larger issue for practice. Also there existed a need to educate healthcare professionals about varying conceptualizations of illness including mental health concerns stemming from historical trauma which require an additional focus beyond diagnosable mental health disorders. Additionally, there exists various barriers to providing care which are quite complex. For example, it is the goal of the family health team model to have collaboration
among health care providers but funding models combined with a pervasive culture of hierarchical structures in health care serves to impede these models.

**Summary and Conclusion**

According to the present research, mental health counselling is conceptualized as a profession, a practice, and a collaborative approach to patient care. It is an evolving process that requires obtaining specialized training and skill in assessing and treating individuals with complex mental health issues. Counsellors need to be highly skilled and willing to work through challenges, all while remaining flexible to learning and adapting to new collaborative approaches to mental health care. While skill is an essential component for starting within the practice, continual skill development is key. Mental health counselling also involves negotiating care within the interprofessional setting both internally within family health teams and externally with other health care settings such as hospitals and community agencies. The present study has added to the research on mental health counselling in family health teams through the development of an integrative model, a new approach to mental health counselling within family health teams.

Within this model of shared care, mental health care is the responsibility not just of the counsellor, but of the patient (or client) and the larger interdisciplinary team. It therefore becomes the task of the mental health counsellor to inspire mental health and wellness through interactions with patients/clients in a professional counselling relationship as well as with other team members. Within this model mental health counsellors serve as leaders in promoting this type of care.

This study has served to address the gaps in the existing literature on the practice of mental health counselling in family health team models. Using a narrative inquiry approach, the researcher provided participants the opportunity to explain how it is that they come to understand
their practice within a family health team model. In turn, participants were able to inform the researcher on the research process. This participatory process served not only as a function of adding to the academic literature on the topic but addressing issues of best practices. It also served as an opportunity for ongoing professional development through speaking to others about how it is that they practice within the setting and how they involve other members of the family health team in the service of providing mental health care.

For me, the researcher, the process of understanding “what am I doing here” has unfolded over the past 6 years. I came to the position of mental health counsellor with several years of prior experience in community mental health and education with emphasis on trauma-informed care and addiction counselling.

Reflecting now on participants’ responses I can understand how the three meta-themes of professional background, professional practice, and interprofessional collaborative care have influenced how I have come to understanding counselling within this setting. For example, my professional background in counselling psychology with graduate training in counselling and psychotherapy rooted in humanistic and non-directive approaches required that I seek out additional training in other evidenced based approaches such as cognitive behavioral therapy. It was an understanding of patient needs in combination with expectations of other team members that I have adapted my approach to care throughout the years. I have also had to learn to assert the role when needed and to involve others in patient care. This occurred also over many years and required development of an understanding of how best to work with other members of the team. Collaboration occurred through a gradual process of getting to know my team members and communicating my role while remaining open to understanding the perspectives of other team members. I have been faced with many challenges but through these challenges I came to understand the dynamics of family health teams. The skills I have learned through graduate
training in post modern theories in combination with this research process have lead to an advanced understanding of how best to serve patients/clients within a family health team setting.
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Appendix A

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Information/consent Letter to Participants

From Researcher Pauline Sestito O’Brien

Winter 2014

Dear Participants

Thank you for considering participating in my research project. As I noted in our first contact, I am currently enrolled in a graduate programme at the Ontario Institute for Studies in Education, University of Toronto. I may also be using the findings of this research for purposes of obtaining my doctorate degree and/or for professional publication. The purpose of this letter is to provide you with information that you will need to understand what I am doing and to decide whether or not to participate. Participation is completely voluntary, and, should you decide to participate, you are free to withdraw at any time. Should you have any concerns about the research, you may at any time contact my faculty supervisor, Dr. Suzanne Stewart at (416) 978-0723 or myself at (905) 517-9754. This research has received ethical approval from the University of Toronto Research Ethics Board. If you have any ethical concerns regarding this study please contact the Office of Research Ethics at (416) 946-3273.

The name of this research project is Mental Health Counselling in Family Health Teams.

The nature and purpose of the research is to examine the experiences of counselling in a family health team setting. The main question that will be examined is what is counselling within a primary health care setting. I am also interested in knowing how interprofessional collaboration influences your counselling practice. The number of participants I hope to recruit is approximately 7-10.

What, essentially, I am doing is asking counsellors to participate in open-ended discussions on their experiences counselling within a doctor’s office or a Family Health Team. I would also like
to examine interprofessional collaboration. The reason that I am inviting you to participate is to help generate discussion on the counselling role in primary care. Your part in the research, if you agree to be involved, is to participate in one individual audio-taped interview.

This study involves you participating in one interview with myself, Pauline Sestito-O’Brien. The interviews will be informal and will last approximately one hour.

We will be engaged in an open interview or dialogue. Areas which I hope to explore include the lived experience of counsellors in primary care, and what how you go about working within clients and other health professionals within this setting.

Examples of questions that I have in mind but may or may not ask depending on priorities which emerge and how the dialogue evolves are:

*How did you come to work within a Family Health Team Setting (a description of your professional journey)?*

*How do you work with clients/patients at an initial visit?*

*How do you work with clients with mental illness?*

*How do you involve other members of the family health team in the counselling relationship?*

*What are your hopes and fears for working within a family health team into the future?*

All information pertaining to this study, including the original or raw data, will be stored under lock and key in my home office. Only Dr. Stewart and I will have access to this raw data. In the transcripts, names and other identifying information about you or your organization will be systematically eliminated. Identifying codes that could connect you or your organization with pseudonyms provided will also be kept under lock and key in the place designated above. The timing for the destruction of the tapes and/or the raw data is 5 years. I will be listening to tapes, transcribing and encoding my research away from the primary health care setting, in my private home office, so as to maintain confidentiality.

As interviewee, you will receive a copy of the transcript of your interview(s). Any section which you request to have deleted from the transcript(s) of your interview(s) will be deleted. You are free to withdraw from the study at any time, and you may request that the entire transcript of your interview be destroyed. Additionally, you may choose not to answer any question. I will be sharing major aspects of my preliminary analysis with you via email and you will have the opportunity to provide feedback to me at this time.

As a participant you may choose to withdraw from this project at any time. If you choose to withdraw all of your information will be deleted from the records kept in the study. All responses that you have contributed within the individual interview will also be deleted from the transcript.
While there will be no compensation, potential benefits which you might derive from participating include the chance to reflect on your own professional practice as well as add to the discussion on counselling practices within family health teams.

There is always the unlikely possibility that items come up that you might find troubling. Please contact me at any time and I will be able to provide you with more information about available support. Also, please note that you may skip any question you wish and still remain in the study.

Below, there is a place for you to sign to give your consent, should you decide to do so. There is also a place for you to add any stipulations. Should you decide to participate, please return one signed and dated copy to me and keep the other for your reference. All participants will receive a summary report of the research findings.

Thank you.

Sincerely,

Pauline Sestito O’Brien

235 Nakoma Road, Ancaster, ON L9G 1S8

(905) 517-9754
To Be Completed by People Choosing to Participate

I have read through this document. I understand and am satisfied with the explanations offered, feel that my questions have been addressed, and agree to participate in the ways described. If I am making any exceptions or stipulations, these are:

_________________________________________________
(insert any stipulations here)

I agree to be audio-taped

_____ YES

initial

_____ NO

initial

______________________________________________ (Signature)
______________________________________________ (Printed Name)
______________________________________________ (Date)
Appendix B

Recruitment Email:

Hello,

My name is Pauline Sestito O’Brien and I am a Masters Level and Canadian Certified Counsellor who practices in a primary care setting. I am also an Ed.D student working under the supervision of Dr. Suzanne Stewart in the Counselling Psychology Department at the Ontario Institute of Studies in Education, University of Toronto. I am contacting you because I am presently recruiting participants for my research project.

I am interested in speaking to counsellors who provide counselling and psychotherapy services within a doctor’s office or family health team setting. The topic of this study is on counsellor’s experiences working with clients and other health professionals in family health teams.

Participation in this study involves meeting with me for one semi-structured interview, approximately one hour in length.

I would like to assure you that the study has been reviewed and received ethical clearance through the Office of Research Ethics at the University of Toronto.

If you are interested in participating, please contact me at pauline.sestito@mail.utoronto.ca or (905) 517-9754. I will travel to your area for the interview.

Thank you for your consideration and please do not hesitate to contact me if you have any additional questions.

Pauline Sestito O’Brien
Appendix C

Recruitment information for list-serv

*Participants needed for a study on mental health counselling in family health teams*

**Participants needed:** Masters-level mental health professionals who are employed as mental health counsellors within family health teams. You have an educational background in social work, counselling psychology, nursing, psychology, marriage and family therapy and refer to your position as mental health counsellor, counsellor, psychotherapist, social worker, mental health nurse. Also your office is located within the family doctor’s office.

**Researcher:** Masters-level mental health counsellor working within a family health team in Ontario with an educational background in counselling psychology and a doctoral student in counselling psychology at the Ontario Institute of Studies in Education, University of Toronto conducting a research study under the supervision of Dr. Suzanne Stewart on counselling within family health teams.

**What is required?** Participation in an hour-long semi-structured interview about your experiences providing counselling services within family health teams.

Interested participants can contact Pauline Sestito O’Brien at (905) 517-9754 or pauline.sestito@mail.utoronto.ca for more information and/or to participate.