8-2017

Satisfaction of Mental Health Services

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Satisfaction of Mental Health Services

by

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A Thesis

Submitted to the Graduate Faculty of

St. Cloud State University

In Partial Fulfillment of the Requirements

For the Degree

Master of Science

In Counseling Psychology: Rehabilitation Counseling

August, 2017

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Abstract

This study utilized a quantitative design, including a cross sectional survey that examined the perceived quality of mental health services. This study examined the clients' level of satisfaction for received mental health services. A survey using a Likert scale was given to participants for this study. The inclusion criteria included: at least one mental health diagnosis, and at least 18 years of age. The questions in this survey were related to the level of satisfaction for participants who are currently receiving mental health services. The number of participants was 72. Each participant completed the informed consent electronically, as well as disclosed their mental health diagnosis in the first part of the survey. The purpose of this study was to compare clients' level of satisfaction who are receiving mental health services among various contexts. Specifically, data was examined by investigating those who attend a mental health clinic and receive services from a mental health specialist versus those who attend a medical clinic and receive services from a primary care provider for mental health services.

Keywords: mental health, quality of services. mental health specialists, primary care providers

Acknowledgements

First and foremost, I would like to thank my family and friends for their endless support during this process. I could not have done it without them in my support circle. I am grateful for their emotional support they have provided me throughout this journey. Secondly, I would like to thank my faculty advisor, Dr. Amy Hebert Knopf for supporting me and my topic of choice for my project. I have appreciated your endless support, encouragement, and time spent on my project to ensure it could be everything I desired it to be. The determination you have showed me in regards to my project has been inspiring to me. Thirdly, I would like to thank Dr. Michele Mahr for the endless encouragement and support you have shown me since the beginning of my project. I have always admired your energetic personality and thoroughly enjoyed working with you. Fourth, I would like to thank Dr. Susan Dowds for her contributions and time made to my project. Finally, I would like to give a heartfelt thank you to Dr. Mary Tacker for her endless support throughout my entire academic career and beyond. Thank you for everything you have taught me thus far. I am inspired by your wealth of knowledge and passion for the field of counseling. I would not be where I am today both personally and professionally without you.

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Chapter I: Statement of Problem

Primary healthcare is about providing essential healthcare, which is universally accessible to individuals and families in the community and provided as close as possible to where people live and work. Hospitals can manage acute episodes of mental illness quite well but do not provide a solution for people with chronic disorders who end up in the admission-discharge-admission cycle, also known as the revolving door syndrome unless there is some type of backed up comprehensive primary healthcare services involved. Primary care also promotes more of a holistic approach to patient care and ensures services are improved (World Health Organization & WONCA Working Parity on Mental Health, 2008).

It is estimated that "over a third of all mental health care in the U.S. is now provided by primary care doctors, nurse practitioners, pediatricians, and family practitioners" and an estimated "seventy percent of primary care doctors practice now involves management of psychosocial issues ranging from marriage counseling to treatment of anxiety and depression." In addition, the demand by patients for mental health care, including substance use treatment has increased leading to the need for primary care doctors to become involved in mental health care. If primary care providers did not provide the service, many individuals would go without it, due to a lack of psychiatrists (Koven, 2013). Similarly, Stream (2016) expresses that primary care physicians have a responsibility, both professionally and ethically to treat the whole person and that includes an individual's mental health. Primary care cannot be practiced without addressing mental health concerns and all attempts to do so is inferior care.

The American Academy of Family Physicians defines primary care as:

> "Care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health

> concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis. Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings. A primary care practice serves as the patient's first point of entry into the health care system and as the continuing focal point for all needed health care services. Primary care practices provide health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care" (The American Academy of Family Physicians, 2016).

Starr (2011), notes that one reason why individuals attend general medical offices for their mental health is because of stigma, ranging from public stigma to self-stigma. Stigma can occur for a variety of reasons. According to Giandinoto and Edward (2014), the public may perceive people who experience mental illness as "strange, frightening, unpredictable, aggressive and lacking self-control and are associated with negative stereotypes such as being violent and dangerous.

Individuals that are apart of one's community does not know that one is seeking treatment for a psychiatric illness when one enters a primary care office. Also, care is more accessible in primary care visits, as it can be harder to get into the mental healthcare system, especially if one is underinsured or uninsured (Starr, 2011). Starr also purports that several psychiatrists prefer that primary care physicians oversee treatment of mild-to-moderate depression and anxiety, and other mental health illnesses that are less severe. Furthermore, primary care physicians are needed so psychiatrists can focus on individuals who have more

complex mental health conditions. As a result of this separation of services, it improves access for all individuals, and decreases the waiting period to schedule and visit a psychiatrist.

Mental health demands are rising in large part due to financial support diminishing at the state level. Due to some places not having psychiatrists and mental health specialists present, it results in family physicians treating mental health concerns (Laff, 2016). According to Laff (2016), family physicians have an advantage to managing clients' mental health because there is already an established trusting relationship and rapport present between the client and provider due to history. As a result, this makes it easier for clients to be open and honest about their mental health. There is also not time spent building trust like there is with a mental health specialist who does not know the client as well.

Behavioral and emotional disorders are among the most frequent diagnoses seen in the primary care setting (Oyama, Burg, Fraser, Graham, & Kosch, 2012). Most outpatient treatment for mental health disorders is delivered by primary care providers rather than psychiatrists, psychologists, or social workers. Studies have shown that 50-90% of those with mental health needs rely solely on their primary care providers for services. In a follow-up study the authors found more than 200 family medicine residents and residency faculty behavioral medicine interventions including counseling were valued, believed to be cost effective and were utilized in the prevention and treatment of both medical and psychiatric disorders. Physicians referred patients to behavioral medicine specialists for interventions, but more than 80% of the physicians provided interventions to their patients themselves. Additionally, most physicians stated they evaluate mental health symptoms in their patients themselves and only 22% refer patients to a mental health professional for evaluation.

Often mentally ill family members can have a formidable impact on the families in which they reside. Therefore, treating mental illness can oftentimes extend beyond the individual patient who has the mental illness. Family physicians have the capability to manage both the mentally ill individual's mental health, as well as provide support to the family if needed and this is an advantage to family providers providing mental health care. Family physicians also have a solid knowledge base of family systems. Physicians who can treat the individual with the mental health concern and provide support to the family at the same time has been found to be most helpful (McBride, 2016).

Most patients with mental health issues will continue to access the health care system through primary care physicians (American Academy of Family Physicians, 2011). Mental health services are an essential element of the health care services continuum. Promotion of mental health and the diagnosis and treatment of mental illness in the individual and family context are integral components of family practice. Through residency training and continuing medical education, family physicians are prepared to manage mental health problems in children, adolescents, and adults. The continuity of care makes early recognition of problems possible. In a recent national survey of mental health care, 18% of the surveyed population with and without a DSM-IV diagnosis sought out treatment during a 12-month period, with 52% of those visits occurring in the general medical, primary sector.

The American Academy of Family Physicians (AAFP) (2011), acknowledges that the desire of patients to receive mental health treatment from their primary care physicians is repeatedly documented. In an effort to continue to provide mental health services to patients, the American Academy of Family Physicians advocates the following principles:

- The AAFP, working through the accredited residency programs will continue to emphasize the importance of mental health care through clinical rotations in both inpatient and outpatient centers of psychiatric care and continued exposure to psychiatric diagnosis and management through the resident continuity clinic.
- The AAFP will continue to advocate for the maintenance and expansion of state, federal and private insurance funding for mental health care. This funding should include adequate funding for inmate mental health care as well as funding for the growing number of military veterans and their dependents requiring mental health services (American Academy of Family Physicians, 2011)

In addition, primary care physicians are important in providing all care, including mental health and substance abuse services because many patients somatize their psychologic issues. One in three patients who visit the emergency room with acute chest pain are suffering from either panic disorder or depression. Approximately 80% of patients with depression present initially with physical symptoms such as pain or fatigue or worsening symptoms of a chronic medical illness. These patients are likely to seek care through the mental health system (American Academy of Family Physicians, 2011).

There are several barriers in managing and treating mental health disorders, including substance use disorders, which is why many clients decide to receive their care for mental health disorders and substance use disorders from their primary care provider. For example, Dr. Julie Anderson (2016), Family Medicine Physician at the St. Cloud Medical Group discusses treatment for addiction. She states, there is competing principles ensuring that patients have adequate pain control and the appropriateness of the prescription that we are writing. A tenth of all people that are hooked on opiates started out with pain medication after surgery. The bottom

line is most people do not become addicted, but there needs to be better screening mechanisms and tools to measure the chance of becoming addicted. "In primary care, we prescribe a quarter of all opioids, in a fourth of all office visits, we have a role to play".

Given the information presented thus far, it is reasonable to assume that there is a strong need to address the quality of services being provided to individuals seeking care for their mental health, including those with substance use disorders and addictive behaviors. It is imperative to examine the gaps in mental health services across healthcare professionals from the perspective of individuals who receive mental health care from their primary care providers. Evaluation of satisfaction of services will help to inform primary care providers to improve services for patients. It is well documented that there are many reasons why individuals see their primary care provider for mental health care, these include: stigma, lack access of psychiatry and counseling services, financial issues and insurance reasons, client's preference and comorbidity of emotional and physical disorders (American Academy of Family Physicians, 2011).

The current study compared levels of satisfaction in individuals who seek mental health care services from their primary care provider versus clients who receive mental health services from a mental health specialist. This study analyzed client's perceptions and perspectives based on their replies to a survey on medication management, mental health diagnosis, and effective or ineffective treatment modalities.

The research question for the study was as follows: "How satisfied are patients with the mental health services they receive from their primary care provider compared to clients who receive mental health services from mental health specialists"? This study hypothesized that more individuals receive mental health care in the medical clinic setting, however, individuals

who receive mental health services from primary care providers will be less satisfied than those who receive mental health services from mental health specialists.

Chapter II: Background

This study reviewed the existing literature on patients who seek mental health care through their primary care provider versus a mental health specialist and why this is becoming a phenomenon today. This provokes an analysis of how clients view the quality of services from the type of health care professional they seek care from, including primary care providers. Most of the literature that was reviewed discussed stigma, lack of access to psychiatry and counseling services, financial issues and lack of insurance coverage, client's preferences and comorbidity of emotional and physical disorders. These topics were discussed by Thornicroft, Lowes, Cunningham and others. Research suggests based on this literature review some reasons why clients are seeking out services through their primary care provider more regularly for their mental health care provider.

Stigma & Discrimination

According to the World Health Organization (WHO) (2001), one in four people will be affected by mental disorders at some point in their lives. Around 450 million people currently suffer, placing mental health among the leading cause of ill-health and disability worldwide. Depressive disorders are already the fourth leading cause of the global disease burden. Depressive disorders are expected to rank second by 2020 behind heart disease, but ahead of all other diseases. Yet, nearly two thirds of individuals with a known mental health disorder never seeks treatment from a health professional due to stigma and discrimination.

The World Health Organization (2007), discusses that stigma is one of the common reasons why patients have turned to primary care for their mental health. In addition, because primary healthcare services are not associated with specific health conditions, stigma is reduced, which makes this type of care much more popular and acceptable for patients. The reduced

stigma associated with receiving care in primary healthcare settings can also mean individuals with mental health disorders are less likely to experience discrimination in their community. There is also better acceptability linked to reduced stigma and easier communication with primary care providers.

In another study, by Thornicroft (2008), found that three reasons individuals do not seek treatment are the following: (a) because of reluctance to seek help for mental illness related problems because of their anticipation of stigma should they be diagnosed. (b) The second reason clients sometimes do not seek treatment is because of fear and shame of rejection if they disclose their condition, and (c) how others view individuals with a diagnosis of mental illness. Thornicroft suggests that there is no known society or culture in which people with mental illness are considered to have the same value and to be as acceptable as people who do not have mental illness. Further, he purports that rejection and avoidance of people with a diagnosis of mental illness appears to be a universal phenomenon.

Mental health treatments and services have improved greatly over the past 50 years. However, many people who might benefit from mental health services choose not to obtain them or do not fully adhere to treatment regimens once they begin the treatment. Social-cognitive processes motivates people to avoid the label of mental illness that results when an individual is associated with mental health care (Corrigan, 2004). Corrigan (2004), outlines four social-cognitive processes: cues, psychiatric symptoms, social skills deficits, physical appearance and labels. Labels lead to stigma in two ways: one is people can obtain labels from others, such as a psychiatrist, or labels can be obtained by association, such as a person seen coming out of a psychologist's office may be assumed to be mentally ill. Many of the symptoms of severe

mental illnesses are manifest indicators of psychiatric illness that produce stigmatizing reactions. There is great potential for misattributing someone as mentally ill based on these four cues.

Stigma can harm individuals who are labeled publicly as mentally ill in more than one way. Individuals with mental illness are frequently unable to obtain good jobs or find suitable housing because of the prejudice of employers and landlords. Stigma also influences the interface between mental illness and the criminal justice system. Criminalizing mental illness occurs when police rather the mental health system responds to mental health crises, which contributes to the increasing prevalence of people with mental illness in jail. Individuals exhibiting symptoms of mental illness are more likely to be arrested by police than others without a mental illness (Corrigan, 2004).

Corrigan (2004), differentiates between two types of stigma. One is public stigma, or what the public does to the stigmatized group when they endorse the prejudice about that group. The other type of stigma is self-stigma, what members of the stigmatized group may do to themselves if they internalize the public stigma. Research shows that people with mental illness often internalize stigmatizing ideas that are widely endorsed within society and believe that they are less valued because of their psychiatric disorder. Self-prejudice leads to negative emotional reactions, prominent among these is low self-esteem and low self-efficacy. Research has also shown a significant relationship between shame and avoiding treatment. Corrigan describes a study where participants who expressed a sense of shame from personal experiences with mental illness were less likely to be involved in treatment. Self-stigma is influenced by public stigma.

Addiction and substance abuse treatment, just like mental health conditions, also has a great deal of stigma attached to the condition, which makes it difficult for individuals to face it themselves. There also continues to be a general misunderstanding of what addiction is. It looks

a lot like behavior, and therefore, there is a misunderstanding it is a brain disease. Even if an individual does realize there is a problem, there is still a great deal of pressure to deal with it on their own (Amer, 2016). Anderson (2016) adds, we still believe in taking care of ourselves without involving others, or telling others you have a problem. We need to destigmatize that.

Finally, all of these studies and information provides evidence even when there are no major financial barriers, many people still do not seek help in an attempt to avoid being labeled as mentally ill. While, the evidence appears to support "stigma", it still appears to be one of the largest reasons why clients steer away from mental health services, but whether patients feel less stigma with a primary care provider over a mental health provider remains unknown.

Lack of Access

Evidence supports lack of psychiatry and counseling services as another reason people are seeking out mental health services from their primary care provider. Lowes (2016), presents a survey from the Center for Disease Control and Prevention (CDC) and noted that a percentage of people with mental health problems visiting mental health professionals have dropped, suggesting that more patients could be turning to their primary care physicians for mental health treatment instead. This study also provides evidence that there is a shortage of mental health professionals. Lowes (2016), states if there are no good referral choices for the primary care providers to refer the patient to for mental health services, it results in the primary care providers either referring the patient to a specialist outside of the network for the patient, which may become unaffordable for the patient or for the primary care provider to treat clients themselves.

The lack of access to affordable treatment makes the course of the illness more severe and debilitating, leading to a vicious cycle of poverty and mental health disorders that are rarely broken (World Health Organization, 2001). The World Health Organization (2007) outlines

three reasons primary care is more accessible to individuals with mental health conditions. The first reason is there is better physical accessibility because primary health care is the first level of contact and is oftentimes the closest and easiest to access for individuals, families and the community. The second reason is primary care has better financial accessibility as cost of consultation and medications in primary care are often at reduced costs compared to other settings. The final reason is there is reduced chronicity and improved social integration for both individuals with mental health disorders and their households. When individuals are treated somewhere that it is a distance from their home, it disrupts normal daily life, employment, and family life. It removes people from their normal supports, essential to recovery and it imposes more burden on families and caregivers in some situations. With clients receiving services in primary care, in family medicine, the burden on individuals, families and society is reduced and household productivity and social integration will be maintained, resulting in better chances for recovery (World Health Organization, 2007).

Approximately two-thirds of primary care physicians reported in 2004-2005 that they could not get outpatient mental health services for patients, which consists of a rate that was at least twice as high as that for other services. Shortages of mental health care providers, is one important barrier cited by primary care providers in a study conducted by Cunningham (2009). Miller and Druss (2013), reports there is a great potential for family physicians to help fill the mental health gap in the United States. Since there are nearly twice as many family physicians as psychiatrists to be situated in rural areas. They also report that 40% of family physicians report providing mental health services in urban areas with up to 52% providing mental health services in more rural settings.

The prevalence for substance use disorders are on the rise just as much as mental health disorders. Approximately 8% or 21.5 million Americans ages 12 years and older have substance abuse disorders and 1.9 million are addicted to prescription pain medication. Many individuals do not find their way to treatment. More than nine out of 10 adults with substance abuse disorder did not receive treatment in 2015. There are many practical reasons for this. Some of which include, money, transportation, and child care. These have a large impact on receiving the help that is needed. In addition, there are not enough doctors, facilities or funding for everyone needing services (Dickrell, 2016). There is a shortage of doctors who want to specialize in treating addiction, including psychiatrists and doctors able to prescribe medically assisted treatment for addiction (Amer, 2016). Suboxone is a commonly used medication to urge cravings and urges for those battling a substance use disorder, however, there are just not enough doctors with time, the ability or interest to take on prescribing this type of medication as it is time consuming (Dickrell, 2016). Brunner (2016), states, at times, she has had trouble finding other providers to refer to for her patients to.

Finally, these studies and information provided on lack of access is well documented and there is evidence that lack of access is a one of the many reasons why individuals see their primary care provider for mental health related services. It appears that there is a demand for psychiatrists and a minimal supply of psychiatrists and mental health specialists to provide services due to its current shortage of providers in the area of mental health.

Financial & Insurance Barriers

Financial burdens and insurance issues poses as another barrier for individuals to seek mental health services from a mental health care provider and another reason why some individuals go to their primary care provider for mental health services. Mental health care leads

to health care costs of 57 billion dollars in the United States a year. This demonstrates that costs for treating mental health conditions can be quite costly for an individual needing services (Klein & Hostetter, 2014). In addition, currently, there is less than 1% to 1% of a total health budget is allocated for mental health in the United States (World Health Organization, 2001).

Thornicroft (2008), found that approximately 30% of the population worldwide has some form of mental illness and at least two thirds of these individuals receive no treatment. He discusses that two of the reasons individuals do not seek any form of services is because of the low level of coverage of services and because of demand limiting factors such as need for out of pocket payments to afford treatment.

Cunningham (2009), explains how The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 addressed lack of access by requiring group health plans with mental health benefits to provide the same level of coverage as provided for physical health problems. However, even with the Parity law, large gaps in mental health access are still expected to remain. He further explains that uninsured people and even some Medicaid enrollees, public mental health services are underfunded and few private mental health care providers are willing to accept these type of patients. Cunningham found that 59% of primary care providers reported lack of or inadequate insurance coverage as an important reason individuals were unable to get outpatient mental health referrals and services. Also, 51% of primary care providers cited health plan barriers as another important reason for individuals not being able to receive the services needed for mental health.

Prior to the Affordable Care Act, about one third of individuals who were currently covered in the individual market had no coverage for substance use disorder services and nearly 20% had no coverage for mental health services, including outpatient therapy visits and inpatient

crisis intervention and stabilization. Even with these services providing these benefits, the federal parity law did not apply to these plans to ensure that coverage for mental health and substance use disorder services is generally comparable to coverage for medical and surgical care. The federal parity law did not apply to small group plans. Most state parity laws are narrower than the federal parity requirement. Also, 47.5 million Americans lacked health insurance coverage altogether, and about 25% of uninsured adults have a mental health condition or substance use disorder, or both (Beronio, Glied, Po, & Skopec, 2013).

The implementation of effective services has been limited by inadequacies of the behavioral health policy framework, poorly designed payment approaches and dysfunctional and counterproductive regulations. Individuals with severe mental illness who are eligible for both Medicare and Medicaid benefits confront numerous conflicts, which include, regulatory, statutory, and policy-related issues that make navigating the services system confusing and inefficient. Also, conflicts between the two systems also create problems for providers and state program administrators. The lack of coordination Medicare and Medicaid's coverage and payment policies for instance, results in both major service gaps and wasteful duplication. The Affordable Care Act in 2010, raised expectations that care for people with mental illnesses will improve. An estimated 3.7 million more people with severe mental illness would gain access to care through provisions to expand Medicaid, subsidize private insurance for those who are not eligible for Medicaid, and require employers to offer insurance (Mechanic, 2012).

It was also proposed that the Affordable Care Act would prohibit health insurance companies from denying coverage to people with preexisting conditions and the law would create regulated insurance exchanges within each state, which also was expected to help individuals with mental illnesses gain access to health insurance. Innovations introduced by the

Affordable Care Act at the time could facilitate the provision of behavioral health services that are not typically reimbursable, including comprehensive care management, care coordination, social support, transition care, collaborative care and other evidence-based interventions. Several regulations called for by the Affordable Care Act was expected to be finalized between 2012 and 2014. The following are five reasons the Affordable Care Act has made reinventing mental health and substance abuse care in the United States more likely now:

- The Affordable Care Act provisions enable states and federal agencies to test and evaluate improved financial and organizational tools in order to address the fragmentation of services that lead to poor quality and high cost.
- Many provisions, such as health homes, are directed toward chronic disease and co-morbidities. These provisions make it possible for care providers to be more responsive to clients who not only have serious mental illnesses but also have other serious chronic diseases or disease risks.
- The act allows providers to better coordinate Medicaid behavioral services with social service and housing programs that seek to prevent and manage homelessness among people with serious mental illnesses.
- The act encourages the use of preventive services and substance abuse education, evaluation, and treatment, and it allows providers treating people with serious mental illnesses to pay more attention to substance abuse problems.
- By extending the concepts of treatment and related supportive care to such entities as health homes, the Affordable Care Act provides new pathways for incorporating evidence-based treatments, such as supported employment, that are commonly neglected (Mechanic, 2012).

The Affordable Care Act and its implementing regulations, built on the Mental Health Parity and Addiction Equity Act and expanded coverage of mental health and substance use disorder benefits and federal parity protections in three distinct ways: one by including mental health and substance use disorder benefits in the Essential Health Benefits, two by applying federal parity protections on mental health and substance use disorder benefits in the individual and small group markets and three, by providing more Americans with access to quality health care that includes coverage for mental health and substance use disorder services. As of January 1, 2014, approximately 3.9 million people currently covered by insurance in the individual market gained either mental health or substance use disorder coverage, or both. Also, an estimate of 1.2 million individuals currently in small group plans received mental health and substance use disorder benefits under the Affordable Care Act (Beronio et al., 2013).

Secondly, regulations apply federal parity rules to mental health and substance use disorder benefits, which results in Americans accessing coverage through non-grandfathered plans in the individual and small group markets will now be able to count on mental health and substance use disorder coverage that is comparable to their general medical and surgical coverage. Due to this, 7.1 million Americans currently covered in the individual market who currently have some mental health and substance use disorder benefits will have access to coverage of these benefits that conforms to federal parity protections as provided for under the Affordable Care Act and the Mental Health Parity and Addiction Equity Act. In addition, because this will apply to currently enrolled in non-grandfathered plans in the small group market, 23.3 million people currently enrollees in small group plans will also receive the benefit of having mental health and substance use disorder benefits that are subject to the federal parity law (Beronio et al., 2013).

The Affordable Care Act, has expanded coverage to approximately 27 million previously uninsured Americans through access to private health insurance in the individual and small group markets, including Medicaid. In total, through the Affordable Care Act, 32.1 million Americans gained access to coverage that includes mental health and/or substance use disorder benefits that comply with federal parity requirements and an additional 30.4 million Americans who currently have some mental health and substance abuse benefits will benefit from the parity protections (Beronio et al., 2013).

There is a limited capacity to pay for group and individual services privately, publicly or through insurance for substance abuse treatment. The Affordable Care Act and mental health parity law has contributed to assisting this issue. Oftentimes, individuals can get the coverage, but it still may take weeks to get approved. It is not uncommon for individuals battling a substance use disorder to only have a small window of time where they are motivated to make the change in their life and to seek treatment. It is sometimes missed by waiting for approval and if that happens, the motivation may be gone for another long period of time, where the individual does not have the energy or desire to seek treatment again (Hartford, 2016).

Due to the shortage of mental health professionals, primary care providers are struggling to find mental healthcare providers to refer clients to, due to the narrow provider networks fielded by health insurers as a cost-savings response to the ACA. If there are no good referral choice inside the network, clients are faced with going out of network for mental health specialty care, which can become unaffordable for the client (Lowes, 2016).

From data provided, there has been quite a barrier to mental health services for some individuals due to financial reasons as mental health services are costly and insurance barriers due to lack of coverage. Due to the changes in the Affordable Care Act, we see a positive

improvement in the right direction for individuals being able to receive mental health services. However, the issues is by no means resolved and many people are still receiving mental health services from their primary care physician.

Physical & Emotional Disorders Comorbidity

Physical and emotional disorders comorbidity is a final reason a client may choose to see a primary care doctor over a mental health specialist for their mental health care. Comorbidity of emotional and physical disorders is common and a primary care physician can treat and manage both conditions. Failure to recognize and appropriately treat behavioral health conditions has a significant impact on health outcomes and patients are then more likely to be hospitalized for a medical condition and be readmitted to the hospital more frequently (Klein & Hostetter, 2014). Accurate detection and treatment of emotional disorders can have a positive impact on physical health. The consequent morbidity and lost productivity from lack of treatment of psychological conditions are considerable (Oyama et al., 2012).

Mental health is often comorbid with many physical health problems such as cancer, HIV/AIDS, diabetes and tuberculosis, to name a few (World Health Organization, 2007). Mental health and physical health are fundamentally linked. Individuals living with mental health are at a higher risk of experiencing a wide range of chronic physical conditions. In addition, individuals living with chronic physical health conditions experience depression and anxiety at twice the rate of the general population. Co-existing mental and physical conditions can diminish quality of life and lead to longer illness duration and worse health outcomes (Canadian Mental Health Association, 2008).

The American Academy of Family Physicians (2011), presents data on the elderly population with depressive scores, reporting that elderly patients with high depressive scores

increases their risk of coronary heart disease by 40%, with the increased risk of death by 60% when compared to elderly individuals with low depressive scores. Patients with mental disorders have higher utilization rates for general medical services and higher related medical costs than patients without mental health disorders.

Mental illnesses can alter hormonal balances and sleep cycles, with many psychiatric medications having side-effects ranging from weight gain to irregular heart rhythms. This leads to an increased range of physical conditions. Some chronic physical conditions can impact brain function. Emotional stress and chronic pain are both associated with the development of depression and anxiety. Research has been well-established that people with mental illness face a greater risk of developing a range of chronic physical conditions compared to the general population. Higher rates of diabetes, heart disease and respiratory conditions have been noted in individuals with mental health disorder(s) (Canadian Mental Health Association, 2008).

Diabetes rates are significantly high among people with mental illnesses. Both depression and schizophrenia are risk factors for the development of type 2 diabetes due to the impact on the body's resistance to insulin. People with a mental health diagnosis also experience other risk factors for diabetes, such as obesity and high cholesterol levels. On the flip side, people who have diabetes have nearly twice the rate of diagnosed mental health disorders as those without diabetes. Forty of individuals with diabetes also have elevated symptoms of anxiety (Canadian Mental Health Association, 2008).

Individuals with mental illness (es) often have high blood pressure and elevated levels of stress hormones and adrenaline which increase the heart rate. Those with severe mental illness are often treated with an antipsychotic medication and this type of medication has been linked with the development of an abnormal heart rhythm. These all interfere with cardiovascular

function and significantly elevate the risk of developing heart disease among individuals with mental health disorders. Women with depression are 80% more likely to experience heart disease than women without depression. In addition, individuals with mental illness have up to a three times greater likelihood of having a stroke. Conversely, there are significantly elevated rates of depression among individuals with heart disease. It is three times more likely that a person with heart disease will experience depression when compared to people who do not have heart problems. Depression also occurs often following a stroke (Canadian Mental Health Association, 2008).

People living with chronic respiratory diseases experience significantly elevated rates of anxiety and depression. Almost three out of every four people with severe chronic obstructive pulmonary disease (COPD) also experience anxiety and depression. Individuals who experience asthma attacks have a greater likelihood of experiencing anxiety and panic disorders. The current data demonstrates that physical health conditions and emotional disorders can have an impact on one another, which is why one may decide to see a primary care health provider for both conditions, as it is the most convenient. Family physician's contribution to health education, anticipatory guidance, and preparation for crises, as well as making sense of the illnesses for both mental health and physical health can help make functioning, or even survival seem possible (McBride, 2016).

Client Preferences

A study by Oyama et al., (2012), also suggests that physicians believe patients prefer brief office counseling from their physician as opposed to mental health counseling. They also discovered that approximately 80% of patients with symptoms of major and minor depression believed it was important that their primary care physicians offer treatment for their depression;

approximately 90% wanted them to provide counseling, more than 30% wanted them to prescribe a medication and only 5% wanted a referral from their primary care provider to a mental health specialist.

Starr (2011), discusses most patients are treated in general medical offices rather than mental health centers. She explains, that studies indicate that patients, particularly members of racial or ethnic minorities prefer it this way. Lastly, preference may be given to primary care because the continuity of care inherent in family medicine makes early recognition of problems possible. Family physicians treat the whole family and because of this, they are often better able to recognize problems and provider interventions in the family system (American Academy of Family Physicians, 2011). All of the information presented illustrates that a patient who may seek care for their mental health from their primary care provider, is likely not to see mental health care from a specialist.

The primary care sector remains the most common site for delivery, especially for African Americans and Hispanics. In the 1980s, studies showed that African Americans and Hispanics utilized outpatient mental health services for psychiatric symptoms and disorders at approximately half the rate of white individuals. Minority individuals are less likely to seek out help in the mental health specialty settings. However, in primary care settings, ethnic minorities are just as likely as white individuals to discuss mental health problems. According to the NIMH Epidemiologic Catchment Area Study, patients with major depression who reported receiving care in general medical settings without also seeing a specialist in mental health were more likely to be African American than those receiving care in specialty of mental health care settings. Recent work shows that use of outpatient services (primary care) for mental health problems has

increased, particularly for African Americans and Hispanics in general medical settings (Cooper and Gonzales, Gallo, Rost, Meredith, Rubenstein, Wang & Ford, 2003).

Some of the reasons for the increase mental health services for African Americans and Hispanics is because: of these individual's beliefs that life experiences are the cause of depression, that problems should not be discussed outside one's family, mistrust of health care professionals, and concerns about the effects of psychotropic medications. Recent findings suggest that African Americans prefer counseling in primary care settings over medications, but perhaps without desiring a referral to mental health specialists, indicating their preference is counseling type services in the primary care setting provided by medical doctors, or physician assistants (Cooper et al., 2003). The studies presented reinforces the reasons why clients choose to visit their primary care provider for their mental health needs, along with the reasons of stigma, stigma, financial and insurance barriers, and physical and emotional disorder co-morbidity.

After reviewing the literature, there is plenty of evidence of mental health services being provided in the primary care setting and the many reasons that explains this current phenomenon, there is still question as to whether clients are just as satisfied with the services they receive in regards to their mental health from their primary care providers in comparison to mental health specialists.

Chapter III: Methods

This study investigated perceived quality of services and level of satisfaction of mental health services. Two major items were examined: the type of clinic attended and who provided services and level of satisfaction of services. The study utilized a quantitative design using a cross sectional survey to gather the data to measure the quality of services provided.

Participants

Participants in the study met two criteria: 1) they identify as having at least one mental health diagnosis, and 2) were at least 18 years of age. All individuals who met this criterion had equal access and opportunity to participate in the study and take the survey. Individuals recruited to take the survey were current students, both undergraduate and graduate level students in the areas of: Rehabilitation Counseling, Rehabilitation & Addictions Counseling, Psychology and Information Systems, as well as other individuals in the community. All participants were e-mailed with the link to the survey.

Seventy-two individuals initiated the questionnaire and 39 (54.16%) individuals completed the 21 questions. There was 22 (30.55%) individuals who identified themselves as not having a mental health diagnosis, one (.013%) individual who identified as not being at least 18 years old, and there was 10 (13.88%) incomplete surveys. Thus, 33 (45.83%) of the survey responses were excluded from statistical analysis. Of the sample (N=72), 50 (69.44%) identified themselves as having a mental health diagnosis and 22 (30.55%) identified themselves as not having a mental health diagnosis. Seventy-one (98.61%) were at least 18 years of age, while one (.013%) individual was not.

Fourteen (35.89%) of individuals that participated in the study were between the ages of 18-24, 18 (46.15%) between the ages of 25-43, and 7 (17.94%) between the ages of 35-44.

There were no individuals over the age of 44, who participated in the study. These results can infer that perhaps individuals between the ages of 18-34 experience more stressed, resulting in more mental health diagnoses than older individuals. Twenty-nine (74.35%) individuals identified themselves as female, 9 (23.07%) identified themselves as male, and one individual (.025%) identified them as Non-binary/3rd gender.

Twenty-three (58.97%) respondents live in a city or urban community, 12 (30.76%) respondents live in a suburban community, and 4 (10.25%) live in a rural community. Most individuals (N=36) (92.30%) identified themselves as the white/Caucasian race, while 2 (.051%) other participants identified as American Indian or Alaskan Native, while one (.025%) participant identified as a mixed race of white/Caucasian and American Indian. No participants identified as Black or African American, or Hispanic. All (N=39) (100%) individuals who participated in the study, responded that their primary language is English.

Participants were asked to report their mental health diagnoses. They were instructed to report all mental health diagnoses, meaning they could choose more than one if they had more than one mental health diagnosis that was applicable to them. The data is presented in table 5. The following is what was reported: 26 (68.42%) reported having a diagnosis of an anxiety disorder, 25 (65.78%) reported a diagnosis of a depressive disorder, 2 (.052%) reported a diagnosis of Bipolar I disorder, 2 (.052%) reported obsessive-compulsive disorder, 10 (26.31%) reported having post-traumatic stress disorder, one (.026%) reported schizophrenia, 6 (15.78%) reported eating disorders, 8 (21.05%) reported Attention Deficit Hyperactivity Disorder (ADHD), 6 (15.78%) reported substance use and addictive disorders, 3 (.078%) reported borderline personality disorder, and one (.026%) reported an adjustment disorder.

Measurement Tool

The instrument utilized in this study was a cross sectional survey developed by the researcher. The first part of the survey collected demographic information, including age, gender, ethnicity, language preference and what type of clinic is attended, and from whom do clients receive services for mental health issues. The second half of the survey asked participants to use a 5 point Likert scale to rate themselves on how satisfied they are with the care they receive for their mental health. The survey consisted of 21 questions and conducted through Survey Monkey.

Pilot Survey

The survey was piloted to graduate students and 5 graduate faculty members. A consistent suggestion from those who read the pilot survey was to change the following question: I am satisfied with my provider's empathy towards me during my appointments to "I feel satisfied with my provider's compassion towards me during appointments". It was felt that some individuals may misunderstand what the word empathy means. Upon the suggestions, the change was made. A likert scale ratings of: 1. not at all satisfied, 2. not so satisfied, 3. somewhat satisfied, 4. very satisfied and 5. extremely satisfied.

Data Collection Procedure

Upon approval from the Institutional Review Board (IRB) process at St. Cloud State University and changes to the survey based on pilot test, the survey was disseminated to individuals electronically through Survey Monkey. Participants were invited with an electronic invitation by the researcher explaining the purpose of the study and the link to take the survey. Individuals who were interested in participating in the study and taking the survey were instructed to click on the link provided. After entering the link, the participant was presented

with informed consent. Participants were made aware that the study was voluntary and could withdraw at any time while participating. Participants gave consent by entering the survey.

Once they entered the survey. Participants were prompted to answer demographic information questions including providing their mental health diagnoses, what type of clinic they attend for mental health services and what type of provider provides the services. Following these questions, the survey prompted participants to rate themselves using a 5 point Likert scale on how satisfied they felt regarding the services they receive for their mental health. Once they were completed with the survey, and submitted it, participants were brought to a page with the researcher's and committee members contact information in case there were further questions about the study. The study was available for completion from April 14, 2017-July 31, 2017.

Chapter IV: Results

This chapter details the results extracted from the survey that examines clients' level of satisfaction of mental health services they receive from either their primary care providers and mental health specialists, or both. Characteristics of the respondents as well as the frequency they saw their provider, and how satisfied they felt with the services they are receiving for their mental health care. A cumulative summary will be provided at the close of this chapter.

Characteristics of the Sample

The following categories were used to describe the sample: (a) if one had a mental health diagnosis, (b) if one was at least 18 years old, (c) age, (d) gender, (e) type of community lived in, (f) race and ethnicity, and (g) primary language, (h) mental health diagnoses. The type of clinic and type of professionals were used to describe the characteristics of where services were received. Provider's ability, knowledge, availability, compassion, explanation and information, the amount of time spent, how well they listen to client's concerns, overall treatment plan that is created is used to describe how satisfied the clients are with the services they receive.

Data

Table 1

Type of Clinic Attended Frequency Variables

Variable	N	%
Medical Clinic	11	28.20%
Mental Health/Counseling Clinic	22	56.41%
Both	3	7.69%
None	3	7.69%

Eleven (28.20%) of the 39 participants reported receiving mental health care treatment for mental health diagnoses from a medical clinic. Twenty-Two (56.41%) of participants reported receiving mental health care treatment from am mental health/counseling clinic. Three (7.69) participants received mental health services from both a medical clinic and a medical clinic, and 3 (7.69%) receive no care for their mental health diagnoses.

Table 2

Type of provider seen frequencies variables

Variable	N	%
Medical Doctor (M.D.)	9	23.07%
Physician's Assistant (P.A.-C) or Nurse Practitioner (N.P)	1	2.50%
Psychiatrist	0	0.00%
Psychologist	1	2.50%
Counselor	6	15.38%

Nine (23.07%) individuals see only a medical doctor for their mental health services, one (2.50%) sees just a physician's assistant or nurse practitioner, one (2.50%) individual saw only a psychologist, and 6 (15.38%) saw only a counselor for their mental health services. No individuals saw solely a psychiatrist.

Table 3

Type of provider seen frequency variables continued

Variable	N	%
Medical Doctor/Physician Assistant or Nurse Practitioner	2	5.12%
Psychiatrist/Psychologist/Counselor	1	2.50%
Psychiatrist/Psychologist	1	2.50%
Psychiatrist/Counselor	1	2.50%
Psychologist/Counselor	1	2.50%
Medical Doctor/Counselor	7	17.94%
Medical Doctor/Psychiatrist	3	7.69%
Medical Doctor/Psychiatrist/Psychologist/Counselor	3	7.69%
Medical Doctor/Psychologist/Counselor	1	2.50%
Physician's Assistant or Nurse Practitioner/Counselor	1	2.50%
Medical Doctor/Physician's Assistant or Nurse Practitioner/Counselor	1	2.50%
Medical Doctor/Physician's Assistant or Nurse Practitioner/Psychiatrist	1	2.50%

Twenty-three (58.97) individuals sought care for their mental health from more than one provider. One (2.50%) received services from the following combinations of providers: psychiatrist/psychologist/counselor, psychiatrist/psychologist, psychiatrist/counselor, psychologist/counselor, medical doctor/psychologist/counselor, physician's assistant or nurse

practitioner/counselor, medical doctor/physician's assistant or nurse practitioner/counselor, and medical doctor/physician's assistant or nurse practitioner/psychiatrist. Two (5.12%) individuals received mental health services from both a medical doctor and physician's assistant or nurse practitioner, 3 (7.69%) from a medical doctor and psychiatrist, 3 (7.69%) from a medical doctor, psychiatrist, psychologist and counselor, and 7 (17.94%) received mental health services from a medical doctor and counselor.

Table 4

Characteristics of frequencies seen by provider variables

Medical Doctor	Number of years seen	%		Number of times in the past month seen	%	Number of times in past the 6 months seen	%	Number of times in the past 12 months seen	%	Prescribes Medications	
<1 year	2	5.12	0 times	16	41.02	3	7.60	1	2.50	YES	NO
1-3 years	12	30.76	1-3 times	8	20.51	16	41.02	14	35.89	15	5
4-6 years	6	15.38	4-6 times	1	2.50	6	15.46	7	17.94%	Provides Counseling	
7-9 years	2	5.12	7-9 times	0	0.00	0	0.00	1	2.50%	15	11
10 years	2	5.12	10 times	1	2.50	0	0.00	0	0.00%	Does not take Meds	
>10 years	2	5.12	>10 times	0	0.00	1	2.50	3	7.60%	6	

Physician's Assistant or Nurse Practitioner	Number of years seen	%		Number of times in the past month seen	%	Number of times in past the 6 months seen	%	Number of times in the past 12 months seen	%	Prescribes Medications	
<1 year	1	2.50	0 times	4	10.25	3	7.60	1	2.50	YES	NO
1-3 years	3	7.60	1-3 times	2	5.12	3	7.60	5	12.82	3	0
4-6 years	1	2.50	4-6 times	0	0.00	0	0.00	0	0.00	Provides Counseling	
7-9 years	1	2.50	7-9 times	0	0.00	0	0.00	0	0.00	6	0
10 years	0	0.00	10 times	0	0.00	0	0.00	0	0.00	Does not take Meds	
>10 years	0	0.00	>10 times	0	0.00	0	0.00	0	0.00	3	

Psychiatrists	Number of years seen	%		Number of times in the past month seen	%	Number of times in past the 6 months seen	%	Number of times in the past 12 months seen	%	Prescribes Medications	
<1 year	1	2.50	0 times	6	15.38	1	2.50	0	0.00	YES	NO
1-3 years	6	15.38	1-3 times	3	7.60	5	12.82	5	12.82	6	2
4-6 years	0	0.00	4-6 times	1	2.50	2	5.12	1	2.50	Provides Counseling	
7-9 years	0	0.00	7-9 times	0	0.00	1	2.50	1	2.50	8	2
10 years	0	0.00	10 times	0	0.00	0	0.00	0	0.00	Does not take Meds	
>10 years	2	5.12	>10 times	1	2.50	0	0.00	3	7.60	2	

Psychologists	Number of years seen N	%		Number of times in the past month seen	%	Number of times in past the 6 months seen	%	Number of times in the past 12 months seen	%	Provides Counseling
<1 year	1	2.50	0 times	2	5.12	1	2.50	1	2.50	YES 7
1-3 years	2	5.12	1-3 times	4	10.25	1	2.50	1	2.50	NO 1
4-6 years	1	2.50	4-6 times	2	5.12	2	5.12	0	0.00	
7-9 years	2	5.12	7-9 times	0	0.00	1	2.50	2	5.12	
10 years	0	0.00	10 times	0	0.00	0	0.00	0	0.00	
>10 years	2	5.12%	>10 times	0	0.00	3	7.60	4	10.25	

Counselor	Number of years seen N	%		Number of times in the past month seen	%	Number of times in past the 6 months seen	%	Number of times in the past 12 months seen	%
<1 year	7	17.94	0 times	14	35.89	4	10.25	2	5.12
1-3 years	8	20.51	1-3 times	5	12.82	6	15.38	4	10.25
4-6 years	4	10.25	4-6 times	2	5.12	4	10.25	4	10.25
7-9 years	1	2.50	7-9 times	1	2.50	2	5.12	2	5.12
10 years	1	2.50	10 times	0	0.00	0	0.00	0	0.00
>10 years	1	2.50	>10 times	0	0.00	6	15.38	10	25.65

Two (5.12%) had been seeing their doctor for less than a year, 12 (38.46%) for 1-3 years, 6 (15.38%) for 4-6 years, 2(5.12%) 7-9 years, 2 (5.12%) 10 years and 2 (5.12%) had been seeing their doctor for more than 10 years. Medical doctors prescribed medication to 15 (38.46%) of individuals seeing a medical doctor apart of their mental health care. Five (12.82%) reported their medical doctor did not prescribe medications and 6 (15.38%) reported that they do not currently take medications for their mental health. Fifteen (38.46%) participants reported that their medical doctor provided counseling for their mental health and 11 (28.20%) reported they did not receive counseling from their medical doctor. Sixteen (41.02%) had not seen their medical doctor in the last month, 8 (20.51%) had seen their medical doctor 1-3 times, one (2.50%) 4-6 times, and one (2.50%) participant saw their medical doctor 10 times in the last month.

Three (7.69%) had not seen their medical doctor in the past 6 months, 16 (41.02%) people saw their medical doctor 1-3 times, 6 (15.46%) 4-6 times, and one (2.50%) person saw their medical doctor more than 10 times in the last 6 months. One (2.50%) had not seen their medical doctor in the last 12 months, 14 (35.89%) had seen their medical provider 1-3 times in the last 12 months, 7 (17.94%) 4-6 times in the last 12 months, one (2.50%) 7-9 times in the last 12 months, and 3 (7.69%) more than 10 times in the last 12 months.

One (.025%) individual had been seeing their doctor for less than a year, 3 (7.69%) for 1-3 years, one (2.50%) for 4-6 years, and one (2.50%) 7-9 years. Physician's assistant's or nurse practitioners prescribed medication to 3 (7.69%) of individuals seeing a physician's assistant or nurse practitioner apart of their mental health care. Three (7.69%) reported that they do not currently take medications for their mental health. All 6 (15.38%) participants reported that their physician's assistant or nurse practitioner provided counseling for their mental health.

Four (10.25%) had not seen their physician's assistant or nurse practitioner in the last month, 2 (5.12%) had seen their physician's assistant or nurse practitioner 1-3 times in the last month. Three (7.69%) had not seen their physician's assistant or nurse practitioner in the past 6 months, 3 (7.69%) people saw their physician's assistant or nurse practitioner 1-3 times in the last 6 months. One (2.50%) had not seen their physician's assistant or nurse practitioner in the last 12 months, 5 (12.82%) had seen their physician's assistant or nurse practitioner 1-3 times in the last 12 months.

One (2.50%) had been seeing their psychiatrist for less than a year, 6 (15.38%) for 1-3 years, one (2.50%) for 4-6 years, and 2 (5.12%) for more than 10 years. Psychiatrists prescribed medication to 6 (15.38%) of individuals seeing a psychiatrist apart of their mental health care.

Two (5.12%) people reported that their psychiatrist did not prescribe them medication. Two (5.12%) reported that they do not currently take medications for their mental health. Eight (20.51%) participants reported that their psychiatrist provided counseling for their mental health and 2 (5.12%) reported that their psychiatrist did not provide counseling.

Six (15.38%) had not seen their physiatrist in the last month, 3 (7.69%) had seen their psychiatrist 1-3 times in the last month and one (2.50%) had seen their psychiatrist 4-6 times in the past month. One (2.50%) had not seen their psychiatrist in the past 6 months, 5 (12.82%) people saw their psychiatrist 1-3 times in the last 6 months, with 2 (5.12%) 4-6 times, one (2.50%) 7-9 times and one (2.50%) saw their psychiatrist more than 10 times in the past 6 months. Five (15.38%) saw their psychiatrist 1-3 times in the past 12 months, one (2.50%) had seen their psychiatrist 4-6 times, one (2.50%) 7-9 times and 3 (3.69%) had seen their psychiatrist in the past 12 months.

One (2.50%) had been seeing their psychologist for less than a year, 2 (5.12%) for 1-3 years, one (2.50%) for 4-6 years, 2 (5.12%) for 7-9 years, and 2 (5.12%) for more than 10 years. Seven (17.94%) participants reported that their psychologist provided counseling for their mental health and one (2.50%) reported that their psychologist did not provide counseling.

Two (5.12%) had not seen their psychologist in the last month, 4 (10.25%) had seen their psychologist 1-3 times in the last month and 2 (5.12%) had seen their psychologist 4-6 times in the past month. One (2.50%) had not seen their psychologist in the past 6 months, one (2.50%) people saw their psychologist 1-3 times in the last 6 months, with 2 (25.00%) 4-6 times, one (2.50%) 7-9 times and 3 (7.69%) saw their psychologist more than 10 times in the past 6 months.

One (2.50%) individual had not seen their psychologist within the past month, one (2.50%) saw their psychologist 1-3 times in the past 12 months, 2 (5.12%) 7-9 times and 4 (10.25%) had seen their psychologist in the past 12 months

Seven (17.94%) had been seeing their counselor for less than a year, 8 (20.51%) for 1-3 years, 4 (10.25%) for 4-6 years, one (2.50%) for 7-9 years, one (2.50%) for 10 years and one (2.50%) for more than 10 years. Fourteen (35.89%) individuals had not seen their counselor in the past month, 5 (12.82%) saw their counselor 1-3 times, 2 (5.12%) 4-6 times, and one (2.50%) saw their counselor 7-9 times in the past month.

Four (10.25%) had not seen their counselor in the past 6 months, 6 (15.38%) individuals saw their counselor 1-3 times in the last 6 months, with 4 (10.25%) 4-6 times, 2 (5.12%) 7-9 times and 6 (15.38%) saw their counselor more than 10 times in the past 6 months.

Two (5.12%) individuals had not seen their counselor within the past month, 4 (10.25%) saw their counselor 1-3 times in the past 12 months, with 4 (10.25%) 4-6 times, 2 (5.12%) 7-9 times and 10 (25.64%) had seen their counselor over 10 times in the past 12 months.

Composites were created from the survey questions to analyze data. Question 12, "I am satisfied with my provider's ability to effectively diagnose me" and question 13, "I am satisfied with my provider's knowledge about my mental health diagnoses" were added together to create a category about patient diagnosis. Question 14, "I am satisfied with how my provider is able to prescribe me the right medication for my mental health condition" and question 21, "I am satisfied with how my provider listens to my concerns" were composited into a treatment plan category. Question 15 "I am satisfied with my provider's availability to ask questions outside of my appointment times" and question 18, "I am satisfied with the explanation and information I am given on my mental health diagnoses" were composited into an information provided category. Question 16, "I am satisfied with the prompt availability of appointment times with my provider" and question "I am satisfied with how much time my provider spends with me during my appointments" were composited into an appointments category. Finally, question 17, "I am satisfied with my provider's compassion towards me during my appointments" and question 19, "I feel that my provider listens to my concerns" were composited into an appointment interactions category. All composite scores maintain the Likert scale ratings of: 1. not at all satisfied, 2. not so satisfied, 3. somewhat satisfied, 4. very satisfied and 5. extremely satisfied.

A one way multivariate analysis of variance (MANOVA) was used to examine participant satisfaction ratings for five dependent variables which consisted of the five composite scores created: diagnosis, treatment plan, information provided, appointments, and appointment interactions. There was one independent variable, type of clinic attended with four levels (mental health clinic, medical clinic, a combination of mental health clinic and medication clinic, and none). Analyses revealed no significant difference in satisfaction for participants on the variables of diagnosis, $F(3, 35) = 2.11$, $p > .05$, appointments, $F(3, 35) = 1.79$ with $p > .05$, and

appointment interactions $F (3, 35) = 1.49$, $p > .05$. The analysis did, however, reveal significant differences in satisfaction for participants on the variables of treatment plan, $F (3, 35) = 2.98$, $p < .05$, and information provided $F (3, 35) = 3.34$, $p < .05$.

Pairwise comparisons revealed that there are significant difference in satisfaction in the treatment plan category between patients who receive no mental health services (M= 1.50) and those who receive services in a mental health clinic (M= 3.16). and those who receive services in a medical clinic (M=3.05). Thus, patients who receive mental health services in either a mental health facility or a medical facility are more satisfied with their treatment plan than those who receive no services at all.

Pairwise comparisons also revealed that there are significant differences in satisfaction of information provided between patients who receive no mental health services (M=2.00) and those who receive mental health services in a mental health clinic (M=3.80) and those who receive services in a medical setting (M=3.32). In summary, this results in patients who receive mental health services in either a mental health facility or medical facility to be more satisfied with information they are provided than those who receive no mental health services at all.

Table 5

Level of Satisfaction of Services among Different Clinics Types

Survey Item	Medical Clinic Means (Sd)	Mental Health Clinic Means (Sd)	Medical & Mental Health Clinic Means (Sd)	No Current Services Means (Sd)
I am _____ with my provider's knowledge about my mental health diagnoses?	3.82 (1.08)	4.00(1.02)	3.00 (0.00)	3.00(1.00)
I am _____ with my provider's ability to effectively diagnose me	3.64(1.027)	4.00(.076)	3.00(.0.00)	2.67(.58)
I am _____ with how my provider is able to prescribe me the right medication for my mental health condition	2.73(1.62)	2.64(1.89)	1.00(1.00)	.67(.58)
I am _____ with the treatment plan created with my provider	3.36(1.69)	3.68(1.09)	2.67(.58)	2.33(.58)
I am _____ with my provider's availability to ask questions outside my appointment times	3.27(1.42)	3.64(1.00)	3.33(.58)	1.67(.58)
I am _____ with the explanation and information I am given on my mental health diagnoses	3.36(1.29)	3.95(1.05)	2.67(.58)	2.33(.58)
I am _____ with the prompt availability of appointment times with my provider	3.36(1.43)	3.64(1.40)	3.00(1.00)	2.67(1.16)
I am _____ with how much time my provider spends with me during my appointments	3.27(1.49)	4.05(.84)	2.67(1.16)	2.67(.58)
I am _____ with my provider's compassion towards me during my appointments	3.91(1.51)	4.23(.87)	3.00(1.00)	4.00(1.00)
I am_____ with how my provider listens to my concerns	3.64(1.29)	3.95(1.05)	2.67(1.16)	3.00(.00)

Table 6

Composite Scores of Level of Satisfaction of Services among Different Clinics Variables

Variable	Medical Clinic Means (Sd)	Mental Health Clinic Means (Sd)	Medical & Mental Health Clinic Means (Sd)	No Current Services Means (Sd)
Diagnosis	3.73(1.03)	4.00(.95)	3.00(.00)	2.83(.76)
Treatment Plan	3.05(1.15)	3.16(1.18)	1.83(.289)	1.50(.50)
Information Provided	3.32(1.25)	3.80(.91)	3.00(.50)	2.00(.50)
Appointments	3.32(1.25)	3.84(1.03)	2.83(1.04)	2.67(.76)
Appointment Interactions	3.77(1.37)	4.09(.88)	2.83(1.04)	3.50(.50)

Chapter V: Discussion

Data collected for this study was used to determine the research question "How satisfied are patients with the mental health services they receive from their primary care provider compared to clients who receive mental health services from mental health specialists"? Data shows that there was no significant difference between level of satisfaction of mental health services between those who attend a mental health clinic vs. individuals who attend a medical clinic. Thus, the research hypothesis was not supported. However, data did show that there was a significant difference in satisfaction for those who attend a mental health clinic and those who receive mental health services from a medical clinic compared to individuals who are not receiving any mental health services These differences were found in the areas of treatment plan, which includes questions from the survey in the area of provider's ability to prescribe the right medication for mental health diagnoses and the treatment plan created by the provider and information provided, which includes questions from the survey in the area of provider's availability to ask questions outside appointment times and information and explanation given regarding mental health diagnoses from providers.

Limitations

One limitation of this study is the low sample size due to the low response rate. A collaboration had been sought with CentraCare Health and St. Cloud Medical Group on this study, but due to policies, a collaboration was unable to be created. If a study like this were to be completed again in the future, a partnership with health groups could greatly increase the sample size.

Another limitation is testing bias where individuals may interpret rating scales differently. For example, what "somewhat satisfied" means to one participant may not mean the

same thing to another participant. Also, some individuals who fill out surveys may be considered as extreme responders as they like to rate on the outer edge of the scales, while at the same time, other responders, like to stay around the midpoint of the scale. This can make a difference in the data.

Recommendations for Future Research

This study inquired about the quality of services individuals receive and their perceptions on the mental health services they receive from their provider. A future recommendation could be to analyze which areas of mental health services would be the most important for medical professionals to take to enhance their services in their practice.

A second future research recommendation would be to look closer at the newer model called integrated behavioral health services where a mental health specialist and the primary care provider are scheduled where they are in the same appointment with the patient and are actively co-treating the patient at the same time and its effectiveness from both the professionals point of view and the patient's. This is still relatively new, so only some areas are using this model.

A third future research recommendation would be to separate the participants who attend both a medical clinic and a mental health clinic and have them rate the specific providers under each category so it can be determined more clearly where there rating would identify which clinic services they were rating. In this study, if a participant received services in both a medical and mental health clinic, they just rated each question for the combined service, instead of one for medical setting and one for mental health clinic.

Finally, looking at specific populations, such the deaf population, African American community, adolescents to the age of 18 where parents have say in care and comparing them to

this study (that included the general population) and analyze if there is a certain population lacking more than others in the quality of services they receive and what can be done about it.

Conclusion

One recommendation as a result of this study may be building in some counselor education courses throughout medical school training. Another suggestion may be, in medical clinics where trainings on counselor education are offered and provided to medical health care professionals. Additionally, another option could be employing mental health professionals in the same clinic, even area as the primary care providers in order for, so professionals to collaborate. This collaboration would allow clients to receive treatment simultaneously with their primary care provider, while receiving treatment in the area of coping skills.

Essentially, this study revealed there is no significant difference in patient's level of satisfaction for mental health services between a mental health clinic and a medical clinic. However, there was a significant difference between those who receive services from a mental health clinic and those who receive no services and those who receive mental health services from a medical clinic and those who do not receive any services. Since there is no significant difference between levels of satisfaction of services between a mental health and medical clinic, it could mean there is a potential for mental health services to expand in the medical clinic with the right tools, trainings and collaborations made with mental health specialists.

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Appendix A: Consent to Participate

You are invited to participate in a research study about satisfaction of the services you receive for your mental health. To be able to participate in the study you must meet the criteria, which includes being at least 18 years old, and having at least one mental health diagnosis (Anxiety, Depression, Trauma-Related, Eating Disorders, Obsessive-Compulsive Disorder, Autism, ADD/ADHD, Bipolar, Personality Disorders and more) Anything! If you agree to be part of the research study, you will be asked to answer a few demographic questions and then answer questions regarding the care you receive for your mental health.

Benefits of the research being done includes level of satisfaction with services and how satisfied individuals are with their care and to identify gaps among primary care physicians and mental health providers, and the services they provide. By knowing this information, it could result in better care for individuals who have mental health and a better experience for individuals' who are receiving services. There are no anticipated risks with participating in the study.

Data collected will remain anonymous and no identifiable information will be connected to the survey. Results will be made available electronically at the conclusion of the study. No one will be able to be identified through the results as no identifying information will be exposed.

Participating in this study is completely voluntary. By entering the survey below, you are giving consent to participate and to answer the 21 survey questions. Your decision whether or not to participate will not affect your current or future relations with St. Cloud State University, or the researcher. If you decide to participate, you are free to withdraw at any time without penalty. There is no compensation for participating in this study.

Appendix B: Survey

Satisfaction of Mental Health Services Survey

Description: This survey will measure satisfaction levels of the perceived quality of mental health services provided by healthcare providers.
Please answer the following questions by selecting the best answer:

1. Do you have at least one mental health diagnosis? (Choose from yes/no)

2. Are you at least 18 years old? (Choose from yes/no)

3. How old are you? _____

4. Please select your gender
    a. Female
    b. Male
    c. 3rd gender/non-binary
    d. Other
    e. Prefer not to answer

5. Please select your ethnicity:
    a. White
    b. Black or African American
    c. Native American or American Indian
    d. Asian
    e. Other

6. Is your primary language English? (Choose from yes/no)

7. What type of clinic do you attend for Mental Health Services?
    a. Mental Health Clinic
    b. Medical Clinic

8. Please fill out the table

Type of Provider	Times you've seen the provider in the last month?	How many times in last 12 months did you visit the provider?	Counseling (Yes/No)	Medication follow up (Yes/No)	Both Counseling and Medication follow up (Yes/No)
Medical Doctor					
Medical Doctor Assistant (PA-C, NP)					
Psychiatrist					
Psychologist					
Counselor					

9. Please state your mental health diagnoses are. Select all that apply. (Box will be next each option)
    a. Anxiety
    b. Depression
    c. Bipolar Disorder
    d. Obsessive-Compulsive Disorder (OCD)
    e. Post-Traumatic Stress Disorder (PTSD)
    f. Schizophrenia
    g. Eating Disorders
    h. Attention Deficit Hyperactivity Disorder (ADHD/ADD)
    i. Autism Spectrum Disorder
    j. Substance Use & Addictive Disorders
    k. Personality Disorder
    l. Traumatic Brain Injury
    m. Other, Please List: _____

Instructions: Please select your level of **satisfaction** for each question using a scale of **1-5,** with **1** not at all satisfied, **2** not so satisfied, **3** somewhat satisfied **4** very satisfied, and **5** extremely satisfied.

1. I am satisfied with my provider's knowledge on my Mental Health diagnoses

2. I am satisfied with my provider's ability to effectively diagnose me

3. I feel my provider is able to prescribe me the right medication for my mental health condition **(If you are not currently taking medication(s) for your mental health condition, please skip to question 3)**

4. I am satisfied with the prompt availability of appointment times with my provider

5. I am satisfied with my provider's compassion towards me during my appointments

6. I am satisfied with my provider's availability to ask questions outside of appointment times

7. I feel that my provider listens to my concerns

8. I am satisfied with how much time my provider spends with me during my appointments.

9. I am satisfied with the explanation and information I am given on mental health diagnoses

10. I am satisfied with the treatment plan created by my provider

*Survey will was through Survey Monkey