

# OT-led innovations for common mental health recovery and return-to-work in primary care

*First results of an acceptability study*

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*Supported by grants from*





Common mental disorders are among the **leading causes of work disability** worldwide.

**We know what works** for recovery and return-to-work.

**Access** to evidence-based, coordinated care **remains limited.**

## *Ill-equipped family physicians*

- **Limited** mental health & work-focused **training**
- **Limited interprofessional support**

(Boileau-Falardeau et al., 2020; Sylvain et al., 2016)

## *Lack of access to OT services*

- OT services mostly in **private settings**
- Largely **absent from primary care medical home** (*≈ family medicine groups in Quebec*)

(Donnelly et al., 2023)

### *Ill-equipped family physicians*

- **Limited** mental health & work-focused **training**
- **Limited interprofessional support**

### *Lack of access to OT services*

- OT services mostly in **private settings**
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**Puts burden back on patients**

## Our solution?

***Integrating  
Occupational  
Therapists in  
family medicine  
groups***

*(Quebec's PCMH)*



### **Assess baseline acceptability**

of an OT intervention program integrated in family medicine groups (FMG) from the perspective of clinicians and managers.

## Theoretical framework of acceptability (TFA)

*the extent to which people delivering or receiving a healthcare intervention consider it to be appropriate*

### **Affective attitude**

*Level of **comfort** regarding the intervention.*

### **Burden**

*Amount of **effort** required to participate in an intervention.*

### **Ethicality**

*Degree to which the intervention aligns with a person's **value system**.*

### **Intervention coherence**

*Level of **understanding** regarding the intervention's functioning.*

### **Opportunity cost**

*Degree to which benefits are forfeited to engage in the intervention.*

### **Self-efficacy**

*Person's **belief in its capability** to carry out the intervention.*

### **Perceived Effectiveness**

*Perceived potential of the intervention to **meet its goals**.*

## Mixed methods multiple case study



Urban 1  
FMG



Urban 2  
FMG



Rural  
FMG

## 1. Acceptability questionnaire

### Who?

- FMG team members  
*(MD, SNP, nurses, professionals, managers)*

### How?

- TFA questionnaire : 13 items
- 5 level likert scale

1

least acceptable

3

no opinion

5

most acceptable

## 2. Focus groups

### Who?

- Family physician, Specialized nurse, nurse, social worker, managers

### How?

- In person, 90 minutes
- Interview guide based on TFA

## Component 1 *Consultation*

Supporting the **clinical decision-making** of family physicians and nurse practitioners.

(Chan et al., 2020 ; Marois, Durand, et al., 2020)

## Component 2 *Coordination*

**Coordinating** the services required to support recovery and return to work.

(Corbière et al., 2020 ; Marois, Durand, et al., 2020)

## Component 3 *Work rehabilitation & recovery*

Providing work rehabilitation interventions, as described in **therapeutic return-to-work program**, adapted to a **recovery-oriented approach**.

(Corbière et al., 2020 ; Marois, Durand, et al., 2020)

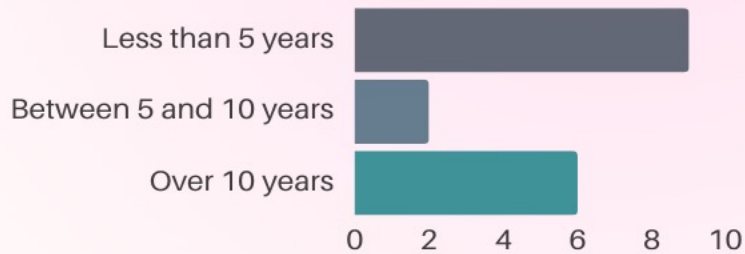
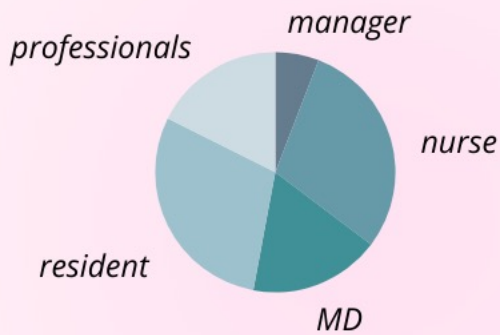
*For patients without insurance coverage allowing access to private services.*

## TFA Questionnaire Socio-demographics

### FMG-1



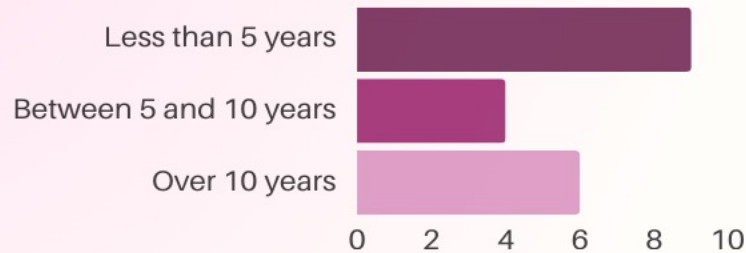
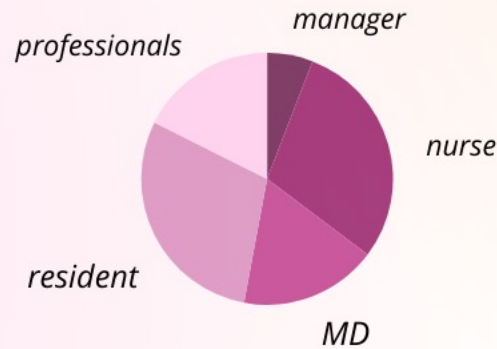
**76.5%**



### FMG-2



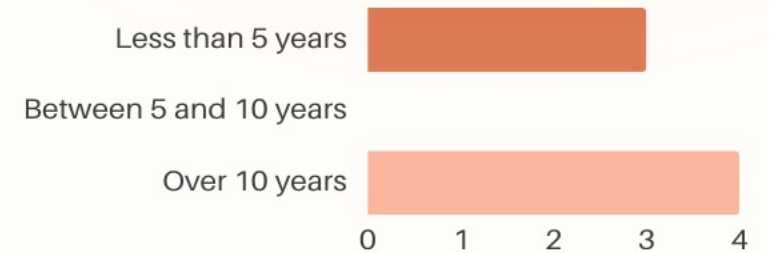
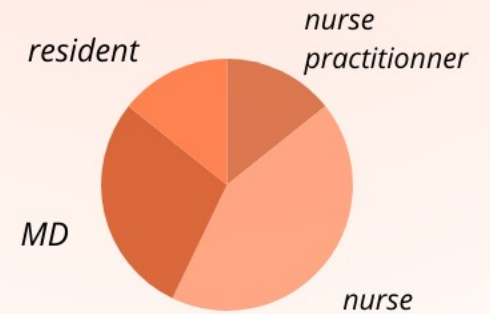
**73.7%**



### FMG-3



**85.7%**



	FMG 1 (n=17)	FMG 2 (n=19)	FMG 3 (n=7)
Affective attitude	4.47 (1.01)	4.53 (0.70)	4.43 (0.79)
Burden	<b>4.47 (0.62)</b>	<b>3.84 (0.60)</b>	<b>3.86 (0.90)</b>
Ethicality	4.88 (0.33)	4.79 (0.71)	4.71 (0.49)
Self efficacy	4.59 (0.80)	4.79 (0.42)	4.43 (0.79)
Effect on recovery	4.88 (0.33)	4.89 (0.32)	4.86 (0.38)
Effect on return to work	4.82 (0.33)	4.84 (0.32)	4.71 (0.49)
Effect on collaboration in FMG	4.82 (0.39)	4.82 (0.37)	4.71 (0.49)
Effect on partner collaboration	4.41 (0.53)	4.74 (0.50)	4.43 (0.79)
Intervention coherence - recovery	4.71 (0.87)	4.47 (0.56)	4.43 (0.79)
Intervention coherence - RTW	4.65 (0.70)	4.42 (0.77)	4.43 (0.79)
Intervention coherence - collaboration	4.41 (0.80)	4.53 (0.51)	4.14 (0.90)
Opportunity cost	4.82 (0.39)	4.89 (0.46)	4.57 (0.53)

1 ————— 3 ————— 5  
 least acceptable                      no opinion                      most acceptable

## Focus group composition



Urban 1  
FMG

**n=10**

- 5 residents
- 1 manager
- 1 social worker
- 1 SNP
- 1 nurse
- 1 Quality and improvement advisor



Urban 2  
FMG

**n=8**

- 3 family physicians
- 1 manager
- 1 social worker
- 1 SNP
- 1 nurse
- 1 Quality and improvement advisor



Rural  
FMG

**n=6**

- 1 family physician
- 1 manager
- 3 nurse
- 1 Quality and improvement advisor



**Overall, high acceptability across key dimensions in three medical clinics.**

## Affective attitudes

- *Positive attitude toward OT and OT integration*
- *Positive review from patients noted*

## Perceived effectiveness

- *Return to work planning*
- *Recovery process support*
- *Service coordination*

## Alignment with primary care values

*“The OT aims to equip the person over the long term in their daily habits — it’s not just about the current episode.*

***So in a way, it’s really about prevention, it’s primary care.”***

## Projecting reduced burden

*Social worker : Having **an OT whose main role is to support** them is really an added value, **it relieves us of that burden.***

## 2

**When intervention coherence is unclear, burden increases and confidence decreases.**

### **Difficulty articulating how OT produces effects**

- *Limited articulation of mechanisms of action*
- *Initial uncertainty regarding referral timing and criteria*



### **Initial efforts perceived as burden**

- *Time and effort required to change referral practices*

### **Reduced perceived self-efficacy in referral and collaboration**

- *Hesitation to initiate referrals early on*
- *Uncertainty about clinical judgment related to OT referral*



## 3

Even with great perceived opportunity cost, contextual conditions shape implementation in primary care.

### Organizational and systemic constraints

- *Remuneration and funding models limit stable, long-term positions*
- *Physical space and clinic organization constrain collaboration*

### Challenges in integrating a new professional

- *Challenges in caseload management*
- *Gap between OT and medical culture*

# Key takeaways

**Clinical teams recognize the value of OT, but integration and practice require stronger support.**

## Implication for research

- *Defining core components of occupational therapy interventions in primary care*
- *Evaluating primary care-based programs, beyond efficacy alone*
- *Implementation studies addressing organizational and systemic constraints*

## Implication for clinicians

- *Practical tools to guide implementation and clinical decision-making in primary care*
- *Communities of practice to support integration and reduce professional isolation*



To read the  
protocol!

Questions,  
comments ?

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# The study

1

## Baseline

### Questionnaires

U-FMG professionals

### Focus groups (n=12)

MD, specialized nurses, managers,  
U-FMG professionals

2

## Intervention phase

OT practice network

Patient acceptability  
data collection

Effects exploration  
data collection

3

## End of project

Collecte de données  
Acceptabilité post-implantation

### Questionnaires

U-FMG professionals

### Focus groups (n=12)

MD, specialized nurses, managers,  
professionals

### Individual interviews

Patients, OTs

# The cases



City 1  
FMG

- 60+ family physicians/ residents
- 3 SNP
- 7 nurses
- 3 social workers
- 3 pharmacians
- 3 physiotherapists
- **1 OT - 4 days/week**



City 2  
FMG

- 50+ family physicians/ residents
- 3 SNP
- 5 nurses
- 1 social worker
- 1 physiotherapist
- **No OT**



Rural  
FMG

- 40 family physicians/ residents
- 3 SNP
- 7 nurses
- 1 social workers
- 1 physiotherapist
- **1 OT - 2 days/week**