

Shared mental health care

Model for supporting and mentoring family physicians

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ABSTRACT

PROBLEM BEING ADDRESSED Family physicians lack access to psychiatrists and mental health services for patients with serious and persistent mental illnesses.

OBJECTIVE OF PROGRAM To develop a mentoring program to provide FPs with education and e-mail, telephone, and face-to-face support for managing patients with mental illness.

PROGRAM DESCRIPTION The Ontario College of Family Physicians' Collaborative Mental Health Care Network developed a mentoring program. Family physicians are grouped according to clinical interest with psychiatrist and general practice psychotherapist mentors whom they can contact for help. Communication is established via e-mail, telephone, fax, or listserv, or even face to face. Monitoring and evaluation is carried out through surveys and chart audits to examine use of, satisfaction with, and effectiveness of the program.

CONCLUSION Mental health care can be enhanced through collaborative at-a-distance relationships between FPs and psychotherapists and psychiatrists. Family physicians can get timely consultation in the areas of psychotherapy and pharmacotherapy, and access to community resources.

RÉSUMÉ

PROBLÈME À RÉGLER L'accès par les médecins de famille à des psychiatres et à des services de santé mentale pour des patients souffrant de maladies mentales graves et persistantes.

OBJECTIF DU PROGRAMME Élaborer un programme de mentorat pour renseigner les MF et leur offrir du soutien par courriel, téléphone ou en personne dans la prise en charge de patients souffrant de problèmes de santé mentale.

DESCRIPTION DU PROGRAMME Le réseau de collaboration en soins de santé mentale du Collège des médecins de famille de l'Ontario a mis sur pied un programme de mentorat. Les médecins de famille sont jumelés en fonction de leurs intérêts cliniques à un psychiatre et à un psychothérapeute en pratique générale agissant comme mentors et à qui ils peuvent s'adresser pour obtenir de l'aide. La communication est établie par courriel, téléphone, télécopieur, listserv ou même en personne. La surveillance et l'évaluation sont effectuées au moyen de sondages et de vérifications de dossiers pour déterminer le recours au programme, la satisfaction à son égard et son efficacité.

CONCLUSION Les soins de santé mentale peuvent être améliorés grâce à des relations à distance en collaboration entre les MF et les psychothérapeutes et les psychiatres. Les médecins de famille peuvent avoir des consultations opportunes dans le domaine de la psychothérapie et de la pharmacothérapie ainsi qu'un accès aux ressources dans la communauté.

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Family physicians are often the primary contact for patients with mental disorders; 30% to 40% of FPs' patients have diagnosable mental health conditions,¹⁻³ and approximately one third of visits to FPs are for mental health problems.^{1,4} Recruitment and retention of FPs and mental health specialists in underserved parts of Canada remain concerns: patients' access to needed mental health care services is limited.

Shared-care models of collaboration between family practitioners and psychiatrists⁵⁻¹¹ have been developed to improve communication between the disciplines, to increase access to psychiatric care and consultation, and to enhance mutual respect between FPs and mental health specialists.¹² Family physicians have difficulty maintaining responsibility for patients with serious and persistent mental illness. Shared care could reduce this difficulty.^{1,13}

Shared care supports FPs while relieving psychiatrists of the day-to-day responsibility of providing primary mental health care. Partnerships between FPs and psychiatrists have been implemented with varying degrees of success both nationally and internationally.⁵⁻¹¹ Traditional shared-care models rely on face-to-face contact and a relatively vertical relationship between FPs and psychiatrists.

Problem

Family physicians' access to mental health services in underserved rural and urban areas is often limited either because specialists are unavailable

or because specialists are unwilling to commit the time required. Use of at-a-distance forms of communication, such as telephone, fax, and e-mail, for shared care have received little attention.^{14,15}

General practitioner psychotherapists provide a type of mental health care that could be particularly useful to FPs since their clinical work often evolves out of traditional family practice. General practice psychotherapists do not usually participate in formal shared-care models nor do they typically collaborate with psychiatrists.

The Ontario College of Family Physicians (OCFP) developed the Collaborative Mental Health Care Network (CMHCN), a unique mentoring program using GP psychotherapists and psychiatrists to help its FP members provide mental health care to their patients. The CMHCN, launched in March 2001, was funded by the Ontario Ministry of Health and Long Term Care.

Objectives of the program include improving collaboration between FPs and specialists in exchange of information and knowledge; enhancing mental health care as defined by the program's goals: to increase physicians' satisfaction with collegial relationships, to improve patients' adherence to treatment, to reduce time to consultation, and to provide optimal treatment and relief of patients' symptoms; providing continuing medical education (CME) as defined by needs assessment; and promoting use of information technology among FPs and specialists.

Program description

The CMHCN evolved out of a perceived need to support FPs in delivery of mental health care through timely access to specialist support and education in the areas of psychotherapy, pharmacotherapy, and community resources. Interested doctors, including GP psychotherapists, psychiatrists, and FPs from academic and community settings, formed a steering committee. In 1999, an assessment of clinical and educational needs in the area of mental health care was mailed to 500 randomly selected members of the OCFP. Fifty respondents reported a lack of access to clinical resources and consultation. Difficult-to-treat conditions included alcoholism and other addictions,

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personality disorders, eating disorders, schizophrenia, and posttraumatic stress syndrome. Pharmacotherapy, specifically use of antipsychotic and mood-stabilizing drugs, was also a problem area. Overwhelming support for a mentoring program was reported; respondents said they preferred telephone and face-to-face contact over e-mail communication.¹⁶

Participants were recruited through an advertisement in the OCFP newsletter that is circulated to all members. Applications for participation were distributed at conferences, including the GP Psychotherapists' Association Annual Conference and the OCFP Annual Scientific Assembly in 2000 and 2001. Finally, an invitation was sent to the heads of all Ontario family medicine departments for them to distribute to local physicians. Any family physician could participate in the pilot project upon request up to a maximum of 100 on a first come, first served basis.

Mentors were selected based on recommendations from psychiatrists participating in shared care and from the GP Psychotherapy Association (because they have expertise in mentoring and physician education in mental health). Mentors' commitment was expected to be no more than 1 hour per week; participants received a stipend for the year. One hundred FPs, 10 GP psychotherapists, and 10 psychiatrists were enrolled. Where possible, FPs and mentors were matched for clinical interests and geographic location in small groups (10 FPs, one GP psychotherapist, and one psychiatrist). Distance was not viewed as a barrier to participation since physicians were expected to communicate by telephone, fax, e-mail, and a listserv. Physicians would request mentoring for managing their mental health patients as needed.

The Steering Committee held a conference to launch the project. The conference brought FPs and mentors together to foster group cohesion and to help participants initiate, organize, and define their collaborative relationships by having them work in their mentoring groups. Plenary sessions were held on "Shared Care and Family Medicine," "Qualities of a Mentor," and "Medical-Legal Issues of the Mentoring Relationship."

Before the program, FPs completed a survey on ease of access to specialist help and knowledge,

satisfaction with consultations, conditions treated, consultative patterns, and comfort with managing mental health conditions, and five patient profiles.

Analysis of 274 patient profiles indicated that:

- family physicians saw an average of 27 patients weekly for mental health problems;
- most such visits were for major depression and marital or family dysfunction (**Table 1**);
- 55% of patients profiled had had formal consultations with psychiatrists in the last year;
- the most frequent conditions requiring consultation were bipolar disorders (76%), schizophrenia (68%), and addictions (68%) (**Table 2**); and
- only 8% of FPs' mental health patients had had formal or informal consultations with GP psychotherapists.

Table 1. Conditions most frequently diagnosed among participants' last five mental health patients: Results of patient profiles (n = 274).

CONDITION	BEFORE PROGRAM (%)	AFTER PROGRAM (%)
Major depression	55	54
Marital or family dysfunction	25	26
Personality disorder	21	20
Addictions	16	21
General anxiety disorder	15	23
Panic disorder	15	12
Sexual or spousal abuse	10	12
Schizophrenia	9	9
Bipolar disorder	8	9
Eating disorder	7	7
Obsessive-compulsive disorder	6	5
Other	33	24

Table 2. Conditions of patients for whom physicians had consulted during the last year: Results of patient profiles (n = 274).

CONDITION	% OF CONDITIONS*
Bipolar disorder	76
Schizophrenia	68
Addictions	68
Sexual or spousal abuse	68
Personality disorder	67

*Some patients had comorbid conditions.

The CMHCN formally commenced in March 2001. Mentors were asked to make initial contact with physicians requiring mentoring to signal their availability and to keep a log of interactions. The program was monitored every 3 months through e-mailed or faxed surveys requesting information on use of and satisfaction with the Network.

Participants contacted mentors by telephone, e-mail, or fax, or in person. Mentoring was scheduled when requested. Informal mentoring occurred when no patient identifiers were used; formal mentoring was more extensive, more often face-to-face, and included specific patient information. Clinical concerns requiring assistance included pharmacotherapy, psychotherapy, physicians' challenges surrounding patient care, and emergency response and intervention (Table 3).

Table 3. Clinical concerns requiring assistance: Results of surveys and evaluation (2002).

PHARMACOTHERAPY: augmentation, discontinuation, use of antipsychotic and mood-stabilizing drugs

PSYCHOTHERAPY: psychotherapeutic impasses, cognitive-behavioural therapy for anxiety disorders, borderline personality disorders, treatment-resistant depression

PHYSICIANS' CHALLENGES: patient care (countertransference, lack of confidence, medicolegal issues), emergency response, crisis intervention

A second conference was held in January 2002 to provide ongoing CME and to build group rapport. Sessions on topics derived from participants' needs assessments were followed by small group mentored case-based sessions. A facilitators' workshop was provided for mentors to introduce them to the competencies required for small group work.

Evaluation

Evaluation of the pilot program and CME events, based on responses to surveys completed before and after the program, patient profiles, and focus groups, is in the preliminary stages.

Network use. Physicians wishing mentoring used the Network an average of 3.3 times, and 58% (32/55) of them consulted psychiatrists or GP psychotherapists, during the 3 months. Family physicians

preferred communicating by telephone (59%); second choice was e-mail (49%).

Benefits and barriers. Physicians reported that the CME sessions and contacts through the CMHCN helped them better assess and manage patients with mental health problems. Analysis of data from focus groups examining program benefits and barriers to Network use (12 participants) indicated that physicians had more confidence, learned more, and referred less after mentoring. Barriers to program use included FPs and mentors preferring different modes of communication, being in different geographic locations, and not having access to Internet and e-mail services. Early analysis of survey data and patient profiles indicated that physicians had better access to specialists (Table 4) and were more satisfied with consultations (44% of FPs and 93% of mentors reported being extremely, very, or fairly satisfied compared with 40% of both before the program) and the help they received (Table 5).

Table 4. Difficulty accessing help: Results of surveys before and after program.

TYPE OF HELP	BEFORE PROGRAM (N = 45) (%)	AFTER PROGRAM (N = 53) (%)
Telephone advice	58	13
Psychiatrists' opinions	30	2
Psychotherapists' opinions	43	4

Table 5. Percentage of family physicians reporting the Network has helped: Results of surveys after the program.

ASPECT	% REPORTING NETWORK HAS HELPED
Increased knowledge	75
Better collegial relationships	75
Improved patient care	88
Decreased time to optimal treatment	68
Amelioration of symptoms	64

Limitations. Evaluation and the experience of CMHCN administration revealed some problems, including a perceived need to better match physicians and mentors by geographic location, a need for increased face-to-face contact to encourage use of the CMHCN, a need for mentors to reach out to

cultivate mentoring relationships, slow response by physicians and mentors, a mismatch in preferred mode of communication between FPs and mentors (telephone vs e-mail), some participants not using the Network, and a lack of formalized FP and mentor expectations.

Many variables, including lack of time, unfamiliarity or availability of mentors, and technology issues, could have contributed to what appears to be less than optimal program use. Frequency of use might not be a measure of success or failure, however, but rather a falling short of Network administration's expectations because there is evidence that confidence in managing mental health issues increased among physicians who only attended CME events and rarely used the Network.

Alternatively, mentors might not actually be underused. Family physicians might be accessing the Network as much as they need to; some could be deriving benefit from simply knowing mentors are available to them.

Program responses to limitations

Geographical matching. More mentors outside the greater Toronto area are being recruited in Hamilton, Mississauga, Thunder Bay, and Ottawa.

Increasing small group sessions. Mentor remuneration has been redistributed on a fee-for-service basis to increase efficient use of Network funds. Mentoring groups will have funds for small group meetings that can comprise case discussions over dinner, videoconferences, teleconferences, and retreats.

Understanding and overcoming barriers to communication. The CMHCN has formalized family physician and mentor expectations of availability and contact: groups must meet two or three times a year, FPs are required to contact mentors six times a year, and mentor response time is now 24 to 48 hours.

Small group sessions at CME events. Annual CMHCN CME events will include small group sessions devoted to evaluating and overcoming obstacles to the mentoring process.

There is consensus among Network participants that this service is necessary and useful. Physicians' satisfaction with the mentoring program and CME as delivered by the Network is high; 79% of participants indicated they wished to continue with the program. The challenge in the second year is to determine what variables (individual preferences, geographic location, increased group contact, better technology) will promote optimal use. The program maintains a lively internal discourse, flexibility, and a spirit of community and good will, which, the organizers believe, will ultimately yield answers to difficulties. In addition, mentors are willing to accept more FPs, which will increase FPs' access to the program.

Technology

The needs assessment reported that mentoring by e-mail was relatively helpful, but e-mail was less widely used than the telephone. This finding is consistent with current research examining physician-patient e-mail practices. Less than 25% use e-mail with their patients; the most commonly cited reason for not using e-mail was preference for face-to-face interaction.¹⁷ Barriers to use of e-mail include lack of access to a computer, unfamiliarity with e-mail, and poor keyboarding skills. Those who did use e-mail reported great satisfaction with this mode of communication because of its ease of use and timeliness.

The program continues to experiment with and encourage use of technology for cost-effective, efficient mentoring (ie, Internet conferencing, group e-mails) but information technology is expected to be an ongoing challenge. We hope that increasing small group contact between mentors and FPs will remove barriers to Network use. Further in-depth analysis of surveys completed 1 year after the program is pending, and more focus groups will be held to determine how the program can better respond to the needs of the OCFP's members.

Conclusion

This unique model of shared mental health care is a variant on traditional programs involving consultation with specialists in their offices. The aim of

the CMHCN is to provide ongoing, at-a-distance, timely access to mentoring for FPs managing mental health care in the community. It has become clear that the success of the program must be both defined and measured by a variety of means, depending on the focus of outcomes: physicians' needs, patients' needs, or program goals.

As the program enters its second year, FP participants seem to be more confident in dealing with mental health concerns. We hope that, as the Network continues and expands, this trend will become clinically and statistically significant. 🍁

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Competing interests

None declared

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EDITOR'S KEY POINTS

- The Ontario College of Family Physicians developed the Collaborative Mental Health Care Network to provide mentoring services from psychiatrists and GP psychotherapists for family physicians having difficulty accessing mental health services.
- This program was unique in including both psychiatrists and GP psychotherapists and in its ways of facilitating collaboration. Telephone and e-mail were most commonly used for ongoing consultations, and two conferences helped build relationships and refine procedures. Face-to-face meetings were not required, permitting greater geographic flexibility.
- Family physicians using the service were very satisfied with the increased access to mental health expertise; 80% would continue to use the program.
- The need for better geographic matching of participants, time pressures, slow development of relationships, and some mismatch in preferred modes of communication (ie, telephone vs e-mail) were issues.

POINTS DE REPÈRE DU RÉDACTEUR

- Le Collège des médecins de famille de l'Ontario a mis sur pied le réseau de collaboration en soins de santé mentale dans le but d'offrir des services de mentorat de la part de psychiatres et de psychothérapeutes généraux à l'intention des médecins de famille qui éprouvent des difficultés à avoir accès à des services en santé mentale.
- Ce programme était unique en ce sens qu'il réunissait à la fois des psychiatres et des psychothérapeutes généraux, ainsi que dans ses façons de faciliter la collaboration. Le téléphone et les courriels étaient les moyens les plus souvent utilisés pour les consultations courantes, et deux conférences ont aidé à établir des relations et à mettre au point les modalités. Des rencontres en personne n'étaient pas nécessaires, permettant plus de flexibilité sur le plan des déplacements.
- Les médecins de famille qui utilisaient le service étaient très satisfaits de l'accès accru à des spécialistes en santé mentale; 80% continueraient de recourir au programme.
- Au nombre des problèmes mentionnés figuraient la nécessité d'un meilleur jumelage géographique des participants, les pressions exercées par le temps, la lenteur dans l'établissement des relations et certaines divergences au chapitre des modes privilégiés de communication (par ex. le téléphone au lieu des courriels).

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