Family physicians and the mental health system

Report from the Mental Health Supplement to the Ontario Health Survey

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ABSTRACT

OBJECTIVE To determine family physicians' role in the mental health care system.

DESIGN The Mental Health Supplement to the Ontario Health Survey is an epidemiologic, retrospective, home-interview survey. Results reported here are based on responses of a weighted sample of patients aged 15 to 64.

SETTING Ontario, 1990 to 1991.

PARTICIPANTS Random sample of 9953 household residents.

MAIN OUTCOME MEASURES Standardized assessment of mental disorders, associated risk factors and disability, and patterns of use of mental health services.

RESULTS More people seek mental health services from their family physicians (FPs) than from psychiatrists, social workers, or psychologists. Among patients who consulted for mental health purposes, more than 35.4% saw FPs only, 24.7% saw FPs and other mental health care providers (psychiatrists, psychologists, social workers, others), and 40% saw other mental health care providers only. There were few sociodemographic, diagnostic, or clinical severity differences between the FP-only group and the other two groups. Some evidence suggested FPs saw more recent onset cases, but they were also involved in joint care for more complex or disabled cases. More than 57% of those seeing FPs received medication; 43% received other forms of care. Those seeing FPs only made four visits per year; those who consulted other mental health professionals made 14 to 20.

CONCLUSIONS Our study confirms FPs' important role in the current mental health care system.

RÉSUMÉ

OBJECTIF Préciser le rôle des médecins de famille dans le système de soins de santé mentale.

CONCEPTION Le supplément sur la santé mentale annexé au rapport de l'enquête ontarienne sur la santé est le résultat d'une enquête épidémiologique et rétrospective basée sur des entrevues effectuées à domicile. Les résultats que nous rapportons ici proviennent des réponses fournies par un échantillon pondéré de patients âgés de 15 à 64 ans.

CONTEXTE Ontario, de 1990 à 1991.

PARTICIPANTS Échantillon aléatoire de 9953 personnes résidant à domicile.

PRINCIPALES MESURES DES RÉSULTATS Évaluation standardisée des troubles mentaux, des facteurs de risque associés, des incapacités et des modes d'utilisation des services de santé mentale.

RÉSULTATS Pour leurs services de santé mentale, les gens ont davantage recours à leurs médecins de famille (MF) qu'aux psychiatres, aux travailleurs sociaux ou aux psychologues. Parmi les patients qui ont consulté pour des services de santé mentale, plus de 35,4 % ont consulté exclusivement leurs médecins de famille, 24,7 % ont consulté leurs MF et d'autres intervenants en santé mentale (psychiatres, psychologues, travailleurs sociaux et autres) et 40 % ont consulté exclusivement d'autres intervenants en santé mentale. On a constaté peu de différences en termes sociodémographiques, diagnostiques ou de sévérité clinique entre le groupe ayant consulté seulement leurs MF et les deux autres groupes. Les données indiquent que les MF voient davantage de cas d'apparition récente et qu'ils sont également impliqués conjointement dans des soins pour des problèmes plus complexes ou des cas d'incapacité. Plus de 57 % des patients traités par les MF recevaient une médication ; 43 % recevaient d'autres formes de soins. Les patients traités par les médecins de famille effectuaient seulement quatre visites par année ; ceux qui consultaient d'autres professionnels de la santé mentale en effectuaient de 14 à 20.

CONCLUSIONS Notre étude confirme l'importance du rôle des médecins de famille dans le système actuel de soins de santé mentale.

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Family physicians (FPs) estimate that a sizable proportion of their patients have mental health problems.[1] Family physicians' importance in delivering mental health services was recognized more than 30 years ago in the seminal work of Shepherd et al.[2] Studies have been done on the United Kingdom's "stepped care" system, where FPs act as gatekeepers to specialized care and where, consequently, their treatment of identified mental health cases and the factors associated with referral are more easily studied.

Even in countries such as the United States, where FPs can be short-circuited as gatekeepers, FPs remain the single provider most commonly consulted for mental health services. The epidemiologic catchment area studies in the early 1980s provided population-based information and found that 6.4% of the US population sought care from the general medical system and only 5.9% sought care from specialists.[3,4] In Edmonton, Bland et al,[5] using a similar design, found higher rates of FP use in Canada than in the United States: 7.9% saw FPs for mental health reasons in the previous year, 1.8% psychiatrists, 2.0% psychologists, and 1.8% social workers. These studies also found that the prevalence of mental disorder (including mainly anxiety, depressive, and substance abuse disorders) is high, ranging from 20% to 30%, and that most people (71.5%) with current mental disorders have not sought care for them in the previous year.[4]

Although several studies have identified factors associated with seeking mental health care,[6,7] few have explored the factors associated with choosing FPs rather than specialists for this care.[8] Leaf et al[3] compared FP-only with specialist care, but excluded patients who contacted both because the rate was too low in the United States (only 0.9% of the population, about 13% of mental health care seekers).

This article uses the 1990 to 1991 *Mental Health Supplement to the Ontario Health Survey*[9,10] to describe and further explore the role of family physicians in Canada. Three groups are compared: those seeking care from FPs only, those seeking care from mental health professionals only, and those seeking care from both. This comparison will expand on previous reports, which have not examined the role of family physicians in joint care. In describing family physicians' actual mental health care activities, we hope to provide both general medical and specialty sectors with a more systematic view of their roles.

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METHODS

The Supplement is a household survey of 9953 Ontario residents, conducted in 1990 and 1991, to assess the prevalence of mental disorders and associated risk factors, disability, and health care system use.[9] It followed up the 1990 Ontario Health Survey (OHS), a provincial government study of the health status and health care practices of the general population. The OHS sample selected households using a stratified, multistage design and was divided into quarterly segments; each segment was representative of the entire province. For the Supplement, one resident (age 15 or older) was randomly chosen from households participating in the last OHS segment. Interviews were highly structured and were administered face-to-face by trained interviewers.[10]

Data were weighted to compensate for lack of response, to reconcile the age and sex profiles of the sample with that of the 1991 provincial population, and to adjust for the complex sampling design. Analyses were conducted only on the population aged 15 to 64 because few disorders were assessed among people older than 65. Also excluded were respondents who failed to answer the use-of-services questions, for a total raw number of 7974 respondents. For the analyses, information was drawn from three sections of the questionnaire.

Use of services. The Supplement included a section on seeking services for mental health reasons. Respondents were asked, "Did you go to any of the professionals on this list for problems with your emotions, nerves, or your use of alcohol or drugs?" Specialty-sector use was defined after Leaf et al[3] and included contacts with psychiatrists, psychologists, and other mental health professionals (ie, social workers, nurses, occupational therapists). Respondents were classified according to four patterns of use: saw a FP in the past year for mental health reasons (FP-only group); saw a FP and a specialist (joint-use group); saw only a specialist (specialty-only group); and none of the above (no-use group).

Mental disorders. Mental disorders were assessed using the latest version of structured interviews developed by the World Health Organization. The University of Michigan Composite International Diagnostic Interview was administered to all

Table 1. Demographic and social characteristics of respondents (n = 7974) with percentages weighted for study design: *Statistical comparison conducted and reported on for FP-only versus joint-use groups and for FP-only versus specialty-only groups*

CHARACTERISTIC	NO PROVIDER SEEN (93.9%) N = 7462	FP ONLY (2.2%) N = 172	JOINT USE* (1.5%) N = 135	SPECIALTY ONLY (2.4%) N = 205
Sex				
• Female	49.3%	68.9%	56.1%	63.3%
• Male	50.7%	31.1%	43.9%	36.7%
Age (mean, 95% CI)	36.6 (36.2-37.1)	38.2 (35.6-40.9)	37.5 (34.5-40.4)	31.6 (29.2-34.1)†‡
Marital status				
• Married	67.5%	70.2%	52.0%	47.4%†§
• Single	27.0%	19.9%	26.7%	38.9%
• Separated, divorced, widowed	5.6%	10.0%	21.3%	13.7%
Completed postsecondary education	27.8%	26.1%	21.7%	36.1%
Unemployed	9.6%	19.6%	19.1%	9.2%†‖
Low income	8.0%	18.7%	20.1%	12.3%
Receiving family benefits	3.6%	7.6%	23.7%¶#	10.6%
Mean days unable to perform (95% CI)	1.2 (1.0-1.4)	3.5 (1.5-5.5)	7.2 (4.3-10.2)¶**	2.5 (1.2-3.7)

**Family physician and at least one of psychiatrist, social worker, psychologist, or other health professional (nurse, occupational therapist, etc).*
†Significant results for FP-only vs specialty-only groups.
‡F = 13.4; 1/174 df; P = 0.0003.
§χ^2 = 9.7; 2 df; P = 0.008.
‖χ^2 = 3.9; 1 df; P = 0.05.
¶Significant results for FP-only vs joint-use groups.
#χ^2 = 7.1; 1 df; P = 0.008.
***F = 4.73; 1/139 df; P = 0.03.*

respondents by lay interviewers[11]; diagnostic classifications met the criteria of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.[12] Subthreshold disorders, such as minor anxiety or depression, were excluded.

Demographic and social variables. The Supplement sought basic demographic information (age, sex, marital status, education, main activity, income, receipt of family benefits). It also included questions about disability, reported here as the number of days in the last month during which the person had to exert extreme effort to carry out usual activities at work or at home.

Analyses. The relationships of the various clinical, demographic, and social variables to patterns of mental health service use are examined individually. The no-use group is presented for perspective, since factors affecting use of any services have been presented already.[13] Statistical analyses compared the FP-only group with the joint-use and specialty-only groups, using the Statistical Package for the Social Sciences (SPSS-PC for Windows, version 6.1). All results with a *P* value of 0.05 or more are reported. However, because of the number of comparisons made, some significant results might have occurred by chance.

RESULTS

More people seek mental health services from their FPs (3.7%) than from psychiatrists (1.8%), social workers (1.6%), psychologists (0.9%), or other health professionals (0.5%). The overall use rate for any of these

Table 2. Clinical characteristics of respondents (n = 7974) with percentages weighted for study design: *Statistical comparison conducted and reported for FP-only versus joint-use groups and for FP-only versus specialty-only groups*

CLINICAL CHARACTERISTICS	NO PROVIDER SEEN (93.9%) N = 7462	FP ONLY (2.2%) N = 172	JOINT USE* (1.5%) N = 135	SPECIALTY ONLY (2.4%) N = 205
Generalized anxiety disorder	0.5%	5.7%	11.6%	11.9%
Panic disorder	0.6%	7.8%	6.9%	9.2%
Any anxiety disorder	10.0%	38.2%	41.5%	40.0%
Any depressive disorder	2.3%	40.2%	46.8%	26.0%†‡
Alcohol abuse or dependence	3.8%	12.2%	18.3%	14.9%
Drug abuse or dependence	1.0%	3.9%	6.3%	4.9%
Any alcohol or substance abuse	4.4%	13.5%	18.3%	17.9%
Antisocial personality	1.5%	0.4%	9.1%§‖	1.9%
Any anxiety and alcohol or substance abuse	0.9%	1.0%	11.0%§¶	11.1%†#
Any disorder	6.2%	45.6%	51.4%	41.2%
Mean count of disorders (95% CI)	0.2 (.19-.23)	1.2 (0.9-1.5)	1.7 (1.2-2.3)	1.3 (1.0-1.6)
Hierarchy of disorder				
• No disorder	69.6%	23.0%	17.5%§**	29.0%
• Lifetime disorder only	15.6%	8.2%	20.6%	12.3%
• One current disorder only	7.3%	27.0%	10.4%	18.1%
• Two disorders or more	7.5%	41.8%	51.5%	40.5%

**Family physician and at least one of psychiatrist, social worker, psychologist, or other health professional (nurse, occupational therapist, etc).*
†Significant results for FP-only vs specialty-only groups.
‡$\chi^2 = 4.0$; 1 df; $P = 0.04$.
§Significant results for FP-only vs joint-use groups.
‖$\chi^2 = 6.6$; 1 df; $P = 0.01$.
¶$\chi^2 = 7.0$; 1 df; $P = 0.008$.
#$\chi^2 = 7.5$; 1 df; $P = 0.006$.
***$\chi^2 = 9.6$; 3 df; $P = 0.02$.*

professionals in the previous year was 6.4%. Among those who sought help, 35.4% saw FPs only, 24.7% saw FPs and specialists, and 40% saw specialists only. These three groups were compared on various demographic, social, clinical, and treatment dimensions.

Table 1 shows demographic and social characteristics. When the three use patterns are considered, some differences emerge between the FP-only group and the two other groups. Members of the joint-use group were likely to be more disabled and receiving family benefits; members of the specialty-only group were younger and less likely to be married.

Those who use mental health services are more likely to have current disorders than non-users (**Table 2**). Clinical characteristics of the three groups are similar in many respects. In general, the joint-use group had higher rates of disorder, although this reached statistical significance only for antisocial personality and the combination of anxiety and alcohol or substance abuse. To explore whether severity of disease or recent onset played a role, a hierarchy of disorders was created and is shown as the final item in **Table 2**. The FP-only group were more likely than the joint-use group to have only one current disorder and no history of disorder. This might indicate that new onset and less severe disorders are more likely to prompt a first consultation with a FP. However, among the FP-only group, 42% had more than two disorders, making their cases severe and potentially complex to treat.

Treatment provided by FPs differed in two ways (**Table 3**); care involved fewer visits and, quite expectedly, patients of the FP-only group and the joint-use

Table 3. Services use and treatment received (N = 7974) with percentages weighted for study design: *Statistical comparison conducted and reported on FP-only versus joint-use groups and for FP-only versus specialty-only groups*

SERVICES	FP ONLY (35.3%) N = 172	JOINT USE* (24.6%) N = 135	SPECIALTY ONLY (40.0%) N = 205
Other professionals seen			
• Psychiatrists		50.4%	42.3%
• Social workers		37.9%	44.0%
• Psychologists		26.3%	18.7%
• Other (nurses, occupational therapists, etc)		19.8%	8.7%
Mean number of visits last year (95% CI)	4.1 (2.8-5.4)	21.5 (14.9-28.1)†‡	14.0 (9.4-18.7)§‖
Treatment			
• Medication	57.1%	64.9%	27.4%§¶
• Other	42.9%	35.1%	72.6%

**Family physician and at least one of psychiatrist, social worker, psychologist, or other health professional (nurse, occupational therapist, etc).*
†Significant results for FP-only vs joint-use groups.
‡$F = 36.4$; 1/135 df; $P < 0.00001$.
§Significant results for FP-only vs specialty-only groups.
‖$F = 14.7$; 1/172 df; $P = 0.0002$.
¶$\chi^2 = 13.1$; 1 df; $P = 0.0003$.

group were more likely to be prescribed psychotropic medication. Because the Supplement did not inquire about nondrug therapies, we cannot determine whether these patients received counseling, supportive therapy, or more specific types of psychotherapy.

Family physicians' important role. Our results confirm that more people consulted their FPs in the previous year for mental health purposes than any other single provider. As a group, however, mental health professionals were seen more often and the number of visits to them was four times higher than to FPs, so the total volume of specialty sector use was higher. The higher Edmonton figures for FP use (7.9% vs 3.7%) can be explained partly by the different methods used to assess use and the fact that, overall, urban areas have higher use rates.[13] Because of the limitations of self-report, our results might actually underestimate the role of FPs in mental health care. Nearly 80% of the general population report seeing their FPs in the past year for any reason.[14] Respondents in our analyses are only those who recognized the presence of a mental disorder and a need for care.

More joint care in Canada than in the United States. Contrary to the US situation, where only 13% of mental health services users saw both their FPs and specialists, nearly 25% of Ontario users sought joint care. Further clinical evidence of stepped care was found in the trend toward more severe cases being seen jointly and patients with recent onset disorder seeing only their FPs. The stepped care system, supported in Canada by the universal health insurance program,[15] represents a more integrated system of care and a more rational use of resources.

However, the clinical differences were small and cast doubt on the proper functioning of the stepped care system. Only extensively analysed specific disorders or hierarchy of recency and severity gave clinical evidence supporting the process of stepped care. More troubling was the finding that almost 40% of the cases seen by FPs could be severe cases (more comorbidity or chronicity of disorders) where joint care would be indicated.

Is family physician care appropriate? The role of family physicians in mental health care has often been criticized on the ground that they have little training in counseling and psychotherapy and that they "medicalize" their patients' problems and rely too heavily on anxiety drugs.[16] Our study casts doubt on the belief that FPs provide only drug treatment for mental health problems and suggests that the educational efforts of medical schools have borne fruit. Without detailed process, outcome, and satisfaction surveys, we cannot judge whether the care provided

by FPs only, jointly, or by specialists only is adequate. It would be interesting to examine, through health insurance databases, for example, whether all FPs are involved or only a subgroup who have opted to specialize in mental health care.

Is family physician care more efficient than specialty care? Attention should be paid to the more intensive and costly activities of specialists. Their cases were not found to be more severe or complex than those seen by FPs only. Differences appeared on some sociodemographic variables (being younger, single) suggesting easier access to specialty services. If these patients' disorders were not more severe, however, this might, in some cases, be overprovision of care.[17]

Conclusion

This study indicates the important role FPs play in the current system of mental health care delivery. This role should be further investigated, taking into consideration FPs' obvious contributions rather than having planners or specialists view them as backups in the absence of enough specialists. One important example is our finding that patients seeing their FPs for mental health reasons report that their FPs provide more than medication, an unacknowledged aspect of their work. Specialized services need to improve their links with family and general practitioners[18] so that referral and the provision of joint care is more rational.

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