Rural Psychiatric Services

A collaborative model

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SUMMARY

Psychiatric services are difficult to obtain in rural communities because few psychiatrists practise outside urban centres. Family physicians who are willing to develop their skills with the support of their psychiatrist colleagues could alleviate this problem. This article describes a community mental health clinic where a family physician acts as psychiatric consultant.

RÉSUMÉ

Les communautés rurales éprouvent des difficultés à obtenir des services psychiatriques étant donné le faible nombre de psychiatres désireux de pratiquer en dehors des centres urbains. Avec l'appui de leurs collègues psychiatres, les médecins de famille désireux de développer leurs habiletés dans ce domaine pourraient atténuer le problème. L'article décrit une clinique communautaire de santé mentale où un médecin de famille agit à titre de psychiatre consultant.

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THE DELIVERY OF MENTAL HEALTH services varies extensively depending upon such things as community location; perceived needs; the experience, training, and philosophy of service providers; and political will. While not everyone supports a medical model for the delivery of such services, few would deny the important role of psychiatric consultation. Even so, psychiatric services are lacking in many communities, including those well served by family practitioners and other medical consultants. How, then, can psychiatric consultations be obtained?

The problem

Campbellford, a rural community in southern Ontario, has been chronically underserviced by fully trained psychiatrists. This situation has persisted despite the establishment of a community mental health clinic in 1991. The clinic, comprising a director, two therapists, and a receptionist, has a well defined role and funding available for a psychiatric resource.

However, psychiatrists tend to live and work in larger population centres.[1-3] Even though psychiatrists are practising in towns and cities within 150 km of Campbellford, none have been available to provide consultative services to the clinic, even on an itinerant basis, because of manpower shortages in their own workplaces.

The local manpower plan suggests that Campbellford itself could support a full-time psychiatrist, based on a generally agreed ratio of one clinician per 10 000 persons.[1-3] The literature describes how very difficult it is to attract psychiatrists and retain them in rural areas for many reasons, including problems with personal privacy, lack of access to inpatient services, and an absence of collegial support.[1] Therefore, attracting a full-time psychiatrist was not seriously pursued.

The Community Mental Health Centre in Campbellford is located in Campbellford Memorial Hospital, a primary care rural hospital with 50 acute beds and 25 chronic beds. The hospital is staffed by 11 general practitioners, several itinerant consultants (both surgical and medical), a full-time surgeon, and a GP-anesthetist. Naturally, the family physicians have provided most of the medical care for the 20 000 people in the catchment area that Campbellford serves, including those with emotional or psychiatric illnesses.

In this way, local family physicians provide services to the mentally ill much as their colleagues do elsewhere.[4] Before the mental health clinic was set up, counseling services were provided by one family physician, for whom psychotherapy is a large part

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of his practice, and by other private individuals. Informal helpers were available in this community as in others. Counseling agencies in surrounding larger towns had very long waiting lists. Psychiatric consultations could be obtained in the cities of Peterborough and Belleville, approximately 60 km away. Tertiary referral centres located in Kingston and Toronto are 150 km away. Despite the relative proximity of these resources, accessing them has always been difficult because of heavy demand.

When the Community Mental Health Centre was established in conjunction with the hospital, a wider range of mental health services suddenly became available. Noticeably absent, however, was the vital role of psychiatric consultation and treatment. Clinic organizers had counted on a psychiatric resource to provide assessment, treatment, evaluation of medication use, consultation to clinic therapists and community physicians, and advice regarding programming issues and educational initiatives. Rather than do without this service, the management board supported a decision to enlist the services of a family practitioner with the collaboration and supervision of a psychiatrist colleague in a nearby city.

How the solution works

The strategy was designed as a temporary measure while efforts continued to obtain on-site psychiatric services, and in this context it seemed to make sense. The consultant family practitioner involved was residency-trained and interested and experienced in psychotherapy and mental health planning, both local and regional. Years of family practice in a rural community without a psychiatrist had also provided a practical educational experience. With a psychiatrist colleague willing to provide supervision and backup, the model was ready to be tested.

On average, the consultant family practitioner spent 7 hours a week in the clinic: half providing direct assessment and treatment services for clinic clients and the rest with staff providing case consultations, as well as general input about the services the clinic provides.

Initially, clinic clients were seen by the consultant family practitioner only at the request of clinic staff. Later in the study, clinic clients were also seen at the direct request of colleague general practitioners. No patient was evaluated by the consultant family practitioner without the approval of the client's personal physician (when there was one) and the client's permission to seek that approval. In this way, a client's personal physician could arrange a psychiatric consultation elsewhere if he or she preferred, even if it meant a longer waiting period. In reality, permission was

always freely granted, as the general practitioners in the community knew of and supported the experiment.

During the first year (January to December 1991) 29 clinic clients were evaluated: 24 were referred by clinic therapists, five others directly by their family physicians. Twelve of these patients had previous psychiatric diagnoses. Standard psychiatric formulations were prepared using DSM3-R diagnostic criteria. Most were diagnosed as having affective disorders (17) and personality disorders (12). Substance abuse and anxiety disorders were also common. Organic mental disorder, somatoform disorder, delusional disorder, and dissociative disorder were each diagnosed once. Notably, neither schizophrenia or schizophreniform disorder were diagnosed in the group. Of course, several patients had more than one diagnosis (*Table 1*).

Ten of the 29 patients had a single consultation only, and the others were seen in follow up, usually fewer than five times. Two patients were seen in follow up more than 10 times. Six patients required prompt referral to a psychiatrist for assessment, but none of these had to be sent on an involuntary basis. Three patients were referred for substance abuse treatment, and two were hospitalized in Campbellford Memorial Hospital on an urgent basis and attended by their family physicians. Most of the patients who were referred for formal psychiatric assessment were seen by the psychiatrist who supervised the consultant family practitioner doing the original formulation.

At first, the consultant family practitioner checked each formulation with the supervising psychiatrist by telephone as soon as possible after it was completed. Occasionally this proved difficult because of problems in arranging mutually convenient telephone time. Later, the family practitioner checked only the more urgent cases and discussed the rest in the psychiatrist's office in 1-hour sessions every 6 weeks or so. On one occasion, the psychiatrist supervised on-site at the Campbellford Community Mental Health Centre. By the end of the first year, 22 of the 29 formulations had been reviewed with the supervising psychiatrist.

The psychiatrist's advice in each case was recorded on the client's file and used to guide further treatment. In 15 of the 29 cases, medication was prescribed by the consultant family practitioner and subsequently monitored by either him or the patient's personal physician. A psychiatric process document was designed to keep track of the pertinent data for all clients who had any psychiatric contact and was updated regularly on a computer database (*Figure 1*). Reference to this database provides not only a profile of the psychiatric practice of the clinic, but also verification that supervision has been obtained for each case when indicated.

Disadvantages and advantages

This method of providing psychiatric evaluation does have limitations. An on-site psychiatrist could have provided more consultations over a greater scope of problems. There are financial drawbacks as well. Currently, the OHIP fee schedule in Ontario offers a low rate of remuneration for consultations by general practitioners as compared with qualified psychiatrists. This drawback has been overcome by sessional fee funding from the Ministry of Health, which provides remuneration for physician's time spent apart from patient contact. Without this sessional fee funding, general practitioners would earn more in regular office practice. Family physician colleagues, psychiatric consultants, and outside agencies (such as insurance companies) sometimes question the credibility of family physicians providing psychiatric services. Except for the insurance companies, credibility has been established in Campbellford with the provision of good quality service.

Table 1. **Diagnostic groupings**

DIAGNOSIS	NO.
Affective disorders	17
Personality disorders	12
Substance abuse	7
Anxiety disorders	5
Organic mental disorder	1
Somatoform disorder	1
Dissociative disorder	1
Delusional disorder	1
Schizophreniform disorder	0

Community Mental Health Centre

PROCESS DOCUMENT — PSYCHIATRIC SERVICES

LAST NAME _____ FIRST NAME _____ REFERRAL # _____

IN-PATIENT ____ SEX ____ THERAPIST _____ ADMISSION # _____

SOURCE OF REFERRAL FOR PSYCHIATRIC CONSULTATION: CMHC _____ Family Physician _____ Other _____

PREVIOUS PSYCHIATRIC DIAGNOSIS _____

SERVICE PROVIDED BY: IMK _____ Psychiatrist on Site _____
Psychiatrist Elsewhere _____

LOCATION OF PSYCHIATRIST ELSEWHERE:

Peterborough _____ Belleville _____ Kingston _____ Toronto _____
Oshawa _____ Whitby _____ Ottawa _____ Other _____

PSYCHIATRIC SUPERVISION FOR IMK: By Phone _____ In Person on Site _____
In Person Elsewhere ____ None to Date ____

DIAGNOSIS:
Personality Disorder _____
Substance Abuse _____
Affective Disorder _____
Anxiety Disorder _____
Schizophrenia/Schizophreniform Disorder _____
Organic Mental Disorder _____
Somatiform Disorder _____
Delusional Disorder _____
Dissociative Disorder _____
Other (Specify) _____

SINGLE CONSULTATION ONLY: _____ MEDICATION PRESCRIBED: _____ FORM 1: _____

FOLLOW-UP ASSESSMENTS:
1 only _____
2 - 5 times _____
6 - 10 times _____
More than 10 _____

IMK'S REFERRALS ELSEWHERE:
Other Psychiatrist/Psychiatric Services _____
CMH Hospitalization _____
Schedule 1 Hospital _____
Psychiatric Hospital _____
FourCAST _____
Substance Abuse Treatment _____
PASE _____
Other _____

The advantages are many. Most obviously there is the provision (using existing resources and existing budgets) of "functionally equivalent" psychiatric consultation in the community where none would have been available at all. These are principles embodied in the Graham Report[5] of 1988, a blueprint for the delivery of mental health services in Ontario. Happily, clinic clientele were willing to be evaluated by a general practitioner of the community, even when they were reluctant to see a psychiatrist elsewhere or on-site. Such clients were exposed indirectly to psychiatry, and they did not object to this.

The service was cost effective because there were no travel expenses, and most sessional fees were charged at the lower rate for general practitioners.

The consultant family practitioner appreciated the opportunity to enhance his psychiatric skills. Clinic staff found ready, on-site access to medical and psychiatric input valuable. The psychiatrist has not found the task onerous and it has proven remunerative, his consultation time also being paid for with clinic sessional fees. And of course, firm linkages with surrounding general hospital psychiatric facilities were established providing an improved overall mental health service to the community.

Conclusion

This model, originally planned as a temporary solution, has proved successful over an extended period. Many questions arise, however.

- Is this method of providing psychiatric consultation sufficient to serve a more seriously mentally ill population, including acutely psychotic people and chronic schizophrenics?
- How much mental health care should a primary care physician be expected to provide, even with supervision?
- How much extra training should such a general practitioner have and how should it be provided?
- Most importantly, is the model transferable? Are there general practitioners in other communities willing to do this kind of work, and are there psychiatric consultant colleagues willing to link with them?
- Finally, is the Ministry of Health willing to support the establishment of such linkages in other communities that might not already have access to sessional fee funding? Because there seems little likelihood of psychiatrists choosing to live and practise in rural areas such as Campbellford, we believe that the model described is a successful example of using a family physician as a "psychiatrist extender" and providing regular psychiatric consultation service to an underserviced area of Ontario. ■

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