Shared mental health care
The way ahead

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In almost every Canadian community, family physicians play an important role in handling the mental health problems of their patients. Evidence from Ontario suggests that 35% of people with mental disorders are treated only by their family physicians (compared with 40% being treated by mental health services and 25% receiving care from both family physicians and mental health workers).[1] Despite the potential for complementary roles for primary care and mental health services in delivering mental health care, family physicians often encounter difficulties in working with mental health services.

Canadian studies of the relationship between primary care physicians and mental health services have consistently identified two main problems: perceived lack of respect and support for the role of family physicians as providers of mental health care and difficulties encountered by family physicians in both accessing mental health services and communicating with their colleagues in mental health services.[2]

Both of these issues are discussed in this issue of *Canadian Family Physician* by Brown et al (page 915) and Lucena and Lesage (page 923). Brown and colleagues present a detailed picture of family physicians' current role in managing patients with serious mental illnesses. Two points come through clearly. The first is the strong commitment of the family physicians interviewed to caring for people with serious mental health problems. The second is the desire and need for better collaboration with mental health services, a point echoed by Lucena and Lesage. Of particular importance is the need for a rapid response when patients are in trouble or advice is required.

These articles also touch indirectly on another important issue: what is the best role for family physicians managing people with mental health problems? Which patients are best managed in primary care and which require additional secondary or tertiary services? What treatments work best in primary care? These are important questions because we have an opportunity to define what primary mental health care could be. It needs to be more than just transplanting psychiatric treatments from one setting to another. Treatment principles must be adapted to the demands and constraints of primary care, while integrating the opportunities for prevention and early detection, family involvement, patient education, and continuing care that primary care presents.

New models of collaboration

For primary mental health care to flourish, it must be part of a continuum of care that flows with other specialized services, so patients receive what they need with minimal obstruction. Achieving this, however, requires new models of collaboration. Family physicians are willing and able to manage a range of mental health problems in their practices if they know they have support from their colleagues in psychiatry. Support means easier access to mental health consultation and treatment, and improved backup when family physicians treat patients themselves.

While problems with collaboration continue, the situation is starting to change. In recent years, both specialties have made a stronger commitment to work more collaboratively (shared care). There has been a rapid increase in the number of innovative collaborative projects.[3] While some are large projects, such as those that integrate counselors or psychiatrists within primary care settings, many are small and have been developed within existing service budgets. Their main resources have been goodwill and a desire to bring about changes that will make it easier for patients to receive the services they need as quickly as possible. Central to all these projects, however, is the recognition that stronger personal contacts are the basis upon which collaboration is built.

Both articles by Brown et al and Lucena and Lesage identify the need to reduce or eliminate

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obstacles that could interfere with better collaboration. These obstacles include attitudes, time demands, provincial billing tariffs, and a fragmented planning process at both local and provincial levels.

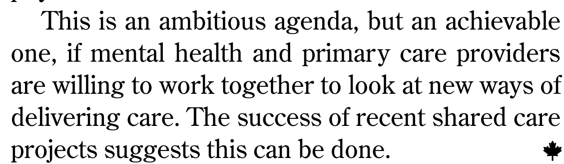
Key elements for collaboration

What then begins to emerge from these studies and other work taking place across Canada is an agenda with 10 important elements for collaboration, which are identified below.

1. ***Strengthening personal contacts between family physicians, psychiatrists, and other mental health workers.*** These contacts can include joint rounds or case reviews and smaller group educational sessions or visits to each others' facilities. As clinicians get to know one another, they will have a chance to address outstanding issues, identify common concerns, and recognize that they share many goals that could lead to ideas for new projects.
2. ***Improving communication.*** This involves transferring relevant information quickly at time of referral and discharge, and making contact after changing treatments.
3. ***Improving access to mental health services.*** This could be accomplished through simpler referral procedures, efforts to reduce waiting lists, and more user-friendly referral forms. It also requires new models for delivering mental health care. For example, an outpatient mental health service with a lengthy waiting list could offer immediate consultation and treatment advice to family physicians, who could then manage patients (with telephone backup) until the mental health service was able to provide ongoing care. Integrating mental health services within primary care settings is another model that has helped increase access to these services.
4. ***Emphasizing early detection.*** Evidence shows that early detection and treatment of mental disorders can lessen the severity of symptoms, improve the course of the disorder, help patients to participate in their communities, and reduce health care costs. Primary care is a key location for early detection of these problems. Programs will be most effective if mental health and primary care providers work together to identify and monitor people at risk and to ensure they have access to mental health services when needed. This can be done by using screening instruments, placing stickers on charts of those at risk, asking three to four routine questions to identify patients at risk for common problems (such as the CAGE questionnaire for detecting alcohol problems), and seeing all teenagers in a practice at least once between the ages of 15 and 18.
5. ***Providing telephone backup by psychiatrists.*** Telephone contact can be invaluable to family physicians for support and advice about specific treatments, management issues, or resource availability for patients they are managing. Consulting psychiatrists need not even be based in the same community.
6. ***Continuing education.*** Programs that focus on shared management of patients are important. The effectiveness of large continuing education workshops and clinical practice guidelines is questionable. We need to develop and evaluate more creative practice-based models of continuing education, such as problem-based small group learning; the Internet; or simple educational aids, such as information sheets on a drug or problem that could accompany psychiatry discharge summaries.
7. ***Training future practitioners.*** Graduates of our residency programs can overcome some of their negative attitudes toward collaboration. Through training they would feel more comfortable working with partners from other disciplines and would have the skills to do so effectively.
8. ***Better integrating mental health and primary care planning processes.*** Better integration is needed in the community and particularly at provincial levels.
9. ***More frequently integrating mental health services within primary care.*** Integration is a logical extension of the desire for collaboration. Integration can improve access to mental health care and increase the capacity of primary care to manage patients' mental health problems. As a result, both patients and providers are highly satisfied, and use of more expensive resources is significantly reduced. Physicians can reach populations who traditionally underuse mental health services and can detect problems earlier.[4] Ideally, mental health services would be integrated in practices of three to 10 physicians in a single site as part of a multidisciplinary primary care team. This team could also include other providers of specialized services, such as nutritionists, pharmacists, optometrists, and palliative care workers.
10. ***Providing new roles for family physicians within mental health services.*** Providing new roles might help resolve

some of the problems of service availability. Examples of family physicians working part time in outpatient clinics or managing inpatient beds on psychiatric units are increasing. These models work best when family physicians have access to and support from psychiatrists and can have an extra year of training in providing mental health care.

Many people with serious mental illnesses have difficulty finding family physicians. If family physicians were part of mental health teams, they could look after the medical problems of patients with serious mental illnesses who do not have family physicians.



This is an ambitious agenda, but an achievable one, if mental health and primary care providers are willing to work together to look at new ways of delivering care. The success of recent shared care projects suggests this can be done.

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