Shared mental health care

Bringing family physicians and psychiatrists together

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If necessity is the mother of invention, then adversity must surely be the father.

Health care in Canada continues to face an onslaught of adversity that is at least 10 years old and getting older. The struggle between the need for universal health care and the increasingly adverse environment in which to provide it has given birth to new ideas and innovations that hold the promise of solution and salvation.

Shared mental health care (SMHC) is one such solution conceived in 1996 by psychiatrists and family doctors. The Blue Paper[1] produced by the Canadian Psychiatric Association and the College of Family Physicians of Canada is a testament to what is possible when a partnership is forged for the purpose of the greater good but is tempered by the knowledge of what limits each of us.

This "brain child" was intended for the benefit of patients and care providers alike. Shared mental health care has taken root in various health care communities across Canada. The result, 8 years later, is a group of partnerships uniquely determined by and intended for the communities within which they exist. Those of us who grew the partnerships in our own backyards have both learned from and molded them. We have watched them grow and shrink, fail and succeed, challenge and be challenged. This process has changed us, changed the way we practise medicine, and changed how we relate to patients and each other.

So, the words in the article by Rockman et al (page 397) sounded hollow to me. "Traditional shared-care models rely on face-to-face contact and a relatively vertical relationship between FPs and psychiatrists."

In this article, 500 family physicians were chosen out of 6400 in the area. Fifty of them returned the surveys—a 10% response rate. How representative is that of the population of providers? The collaborative network was designed by pairing 10 FPs with one GP-psychotherapist and one psychiatrist. The "specialists" were paid for 1 hour per week to connect via telephone or e-mail with any FP in the group who chose to call on them. Both parties had little time and opportunity to get to know each another.

The specialists were paid for their time to provide shared care, but the FPs were not. In the old system, an FP sent a referral out to a stressed mental health care system. This new system allotted 2 hours of "dedicated, paid consultant time" for 10 FPs per week to consult with specialists via telephone or e-mail about pressing patient issues. To the program's credit, a needs-based, case-oriented continuing medical education program developed out of this format.

This model, however, does not appear to reflect the FPs' perspective in providing mental health care. Not all FPs have the skills or are interested in mental health issues. In the fee-for-service environment, where 20 to 80 patients are seen each day, time and endurance are at a premium. If an FP was interested in shared care and spent an hour a week consulting with a specialist, an hour's worth of earning would be lost. Finally, the results suggest slow adoption of e-mail by physicians in the mentoring relationship. The FPs appear to have asked for more face-to-face collaboration.

This trend might reflect the fundamental, intended difference between SMHC and traditional mental health care. Collaboration and partnership are central to the practice of SMHC. These core principles develop over time through shared experiences and communication that starts with

face-to-face meetings. Learning that occurs as a result is at least bidirectional if not multidirectional and definitely not unidirectional.

Mentorship is not enough

Supporting FPs through mentorship is not enough to address the barriers to providing adequate mental health services. We also need resources. There is a rich network of primary care providers in the mental health field that are community- and hospital-based, privately or publicly funded, who would add to the shared care model: social workers, psychologists, mental health nurses, family practice nurses, and occupational therapists. What will it take to include them in the collaborative mental health team? If they could provide mental health services at FPs' offices, working alongside FPs, in consultation with secondary-level psychiatrists, and could participate in the problem-based small group learning that shared care teams lend themselves to (with a specialist phoning in to participate), would shared care become more meaningful to FPs who did not respond to the survey in the first place? Can FPs be paid a stipend for the hour per week they spend in shared care consultation and learning?

Is diagnosis enough?

The article by McIntyre et al (page 388) sheds new light on a mental health illness rampant in primary care: bipolar disorder. The authors quote 2% to 4% prevalence in FPs' practices, necessitating FPs to stay up-to-date. The reality of our lives in primary care, however, is that we are busy, stressed, overwhelmed, and often uninterested due to lack of resources and support from secondary and tertiary care providers. Add to it that we cannot type and do not have time to include new technology into our lives. So, how do you reach FPs whose patients suffer from bipolar disorder?

If shared care is the answer, let us consider a simple fact. Although it is important to keep up with the new pharmacotherapy for treating bipolar illness, this condition is complex enough that no primary care provider (FP, psychologist, social worker, or mental health nurse) should be expected to be the sole provider of care. A secondary-level care provider (general psychiatrist), in collaboration with a tertiary-level care provider (subspecialty psychiatrist), should be available to provide ongoing care for such patients. Primary care providers are adjuncts to care and help with diagnosis, maintenance, and early identification of relapses.

Manassis (page 379) deals with the importance of identifying anxiety disorders in primary care. As a tertiary care specialist, she puts the perspectives reflected in this article in context and succinctly provides information. Once you have learned the importance of recognizing the signs and have prioritized referral of such a patient, how do you deal with the lack of resources with which to make it happen? Access to providers with the expertise for ongoing treatment is as important as identifying the condition.

Experts cannot, however, assume the burden of caring for all those who suffer from anxiety disorders. Developing collaboration between secondary-level and tertiary-level specialists is a potential solution. But consider this: do the 6400 FPs in Ontario know that a child psychiatrist with expertise in anxiety disorders practises in Toronto? Is Dr Manassis accessible to her general psychiatry colleagues? Should she and her expertise not be available to an FP practising in Fort Frances who is just as likely to see a patient (such as the one in her article) in his or her practice? Parents of such a child, whether contributing to the problem or not, have to cope with the reality of how it affects their families and also require support.

Collaborative care is a potential answer but requires a network of providers willing to share the burden of care of such patients and their families.

Finally, the article by Schachter et al (page 405) gives patient-based perspectives about us as caregivers. The need to feel safe was a predominant theme, as was the fervent wish for FPs to address the power imbalance by sharing control and information with patients. Participants stressed the

importance of working in partnership with FPs. The following summary in the words of a patient speaks to the future of collaborative health care: "I think that we're talking about really long-term partnerships with a number of medical people, maybe a physiotherapist, a psychotherapist, a family doctor. We need those nuclei of support, and they all need to be in touch with each other."

In 2004, SMHC is poised to develop into a long-term journey of collaborative learning. Having a variety of perspectives, skill sets, and expertise within collaborative teams will not only enrich the learning environment but also build our capacity to meet patient needs. The diverse needs of our patients have shown us time and again that a single practitioner cannot be all things to all people.

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Reference

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