Abstract: This column reviews the process of developing a collaborative relationship with a group of family physicians in your community or in one that you plan to visit on a regular basis.

Résumé : Entamer et développer une relation de soins partagés dans votre communauté
Cet article examine le processus du développement d’une relation de collaboration avec un groupe de médecins de famille de votre communauté ou d’une autre que vous entendez visiter régulièrement.

Key Words: shared care, collaboration

How Do You Choose?
As shared care becomes more popular, physicians from a group practice in your area may approach you, and you may be chosen. In fact, once your community realizes that you are interested in working collaboratively with family physicians, you may receive several requests.

If you need to choose among several possible groups in your community or chosen area, choose a group of physicians you think you can get along with. You may know them, they may have referred patients to you, you may have met them at continuing medical education (CME) events, or you may have worked with them in the emergency room. It makes eminent sense to choose people you like. Presently, I am working with a group of family physicians who were residents with me when I trained in family medicine; we have a long history of working together in the same community.

You might also choose on the basis of need. There are many small satellite communities surrounding most of the larger centres in Canada that desperately need specialty services. These are often within a one-half to two-hour drive from major centres, and the general practitioners (GPs) in these communities often feel isolated from their colleagues and health services in major centres.

Alternatively you may decide to travel some distance to remote places (that is, northern regions of most provinces), where almost all the medical care is provided by GPs and allied health specialties.

Goals and Objectives of the Collaboration
Negotiate exactly what you want to achieve with your collaboration. This is where the collaboration begins. Meet with the family physicians several times to discuss what they view as their major needs in providing mental health care to their patients. In most cases, their main agenda is to have access to a psychiatrist who will provide useful and timely consultations. Further, they will be interested in providing care to as many in their patient population as possible because of their difficulty in accessing any psychiatric care for their patients.

This is also the time to discuss with the family physicians their point of view on how collaboration will work. What do they see as your respective roles and limits, and how will you share the care of their patients? This will require ongoing discussion and exploration of the capabilities, interests, limits, expectations and capacities for learning for each individual. This is central to developing and maintaining the relationships in collaborative care. It will be best to keep this discussion in the forefront of the relationship for the duration of the collaboration.

Discuss whether it will be important for you to provide either follow-up or psychotherapy (or both) to any of their patients; then, determine how this may affect accessibility. In the same way, it will be useful to talk about how they plan to use you for hallway or face-to-face consultations.

It is necessary in any area of work to identify your limits with respect to how many consultations you can perform weekly. Similarly, clarify your limits of expertise. (Will you see children, adolescents, the elderly, couples, families and disability assessments?) Also, discuss and agree on whether you will be available for emergencies, urgent consultations or telephone contact between clinics.

Describing and Caring for the Process
Decide how often you will visit the practice. One-half day every one or two weeks is often a good place to begin. Choose where you will see patients, because often there will be an office free (for example, one GP might be away on the day that you visit). You may be required to work in an examination room, in which case it is important to ensure comfortable chairs are available. In one practice I
visit, I move from one practice area to the other each time I visit.

Decide on a referral process. Standard referral forms are useful in identifying the main concerns and requests of the physicians and may also be used in collecting data for evaluating the collaboration. Ensure that both the psychiatrist and family physicians have input into selecting the appropriate referral forms.

After psychiatrists have seen patients, they should ensure that the note becomes available in the chart as soon as possible. My notes are generated on a laptop computer, and at the end of each clinic, the secretary receives a floppy disc; hence, these notes are printed and put in the chart the following day. Ensure that handwritten notes are legible; they can be written on coloured paper for easy identification.

Frequency of follow-up or the opportunity to do psychotherapy may change over time as you get busier. Thus, it is useful for psychiatrists to discuss how much of this type of work they want to do. In busy practices with many new referrals, it is possible to get fully booked quickly, and this may begin to limit access. It is a good idea to discuss the process and expectations with the patients early. Identifying treatment goals, clarifying psychotherapy contracts and placing a limit on the number of sessions provided are often necessary. Again, this is a place to negotiate shared care with the family physicians or with other primary care mental health care workers and to involve them in the care and follow-up.

Money: Fee for Service Versus Sessional or Salaried Payment
Money is an issue that requires discussion. Some groups of family physicians will ask that you pay overhead if planning to use their office staff and their space. Other groups, however, will be so happy to have you that they will waive any office overhead fees. If you are in private practice and are already paying overhead, you may need to make this a bottom-line issue.

Many shared care initiatives have been developed in community health centres (CHCs) and in academic centres where money generated only by patient contact is less of an issue. In these settings, it is possible to have meetings to discuss referrals and process without worrying about whether your time is being paid, although in my experience, these practices are often so busy that we have to be disciplined about such meetings.

I did try a collaborative relation with a CHC, whereby the GPs were salaried and I worked fee for service. In this practice, the patients were not especially good about showing up for appointments with either their GP or myself. It wasn’t financially feasible to continue the relationship, owing to the number of patients who did not show up for their appointments.

There have been questions about whether shared care is feasible in fee-for-service settings. In these settings, both the GPs and the psychiatrist will be paid only if seeing patients. Of the eight groups with which I work, four are fee for service, and I see enough patients to generate the same income as in a private practice. Infrequently, I will meet patients with their GP, but this becomes a problem (if done too often), because in Ontario, the GP and the specialist are not allowed to bill for the same patient in the same day.

In fee-for-service practices, hallway consultations occur frequently, and although often brief because both the GPs and I are busy seeing patients, we don’t get paid for these consultations. Overall, in my experience, effective shared care in a fee-for-service environment is possible; however, in a salaried setting or where GPs and psychiatrists are paid for their time rather than by patient encounters, opportunity exists for more collaboration time.

Working with Front-Office Staff
The receptionists, secretaries and nurses in a primary care practice will make or break how the collaboration works. You will spend as much time collaborating with them as you will with family physicians. These people know the patients and their families, the politics of the office and the rules and policies better than many of the GPs. They will be crucial in developing relationships with the clinic, with the GPs and especially the patients and their families. You need to involve these individuals early on in the discussions with respect to the mechanics and philosophy of the relationship.

In the same way, it is essential for the psychiatrist and the GPs to include these individuals in the referral process, in booking patients, in receiving and relaying telephone messages, in communicating with you between sessions, in changing clinic times, in booking holidays and meetings, in feedback from patients, in communicating with your patients over the telephone and in handling emergencies. Moreover, they will become important allies in defining limits and boundaries with both patients and GPs and in developing your own policies within the clinic.

Liasing with Other Mental Health Care Providers
One service that psychiatrists can provide in a collaborative setting is to assist in accessing community and hospital mental health services. If you are doing shared care within the auspices of a community agency, you may be able to negotiate with your group to have one of the agency’s mental health workers visit the clinic on a regular basis. This is a service that most family physicians highly value, particularly if it includes offering counseling and psychotherapy to their patients on-site.

Even in the fee-for-service practices where I work, it is possible to meet with community mental health agencies and to develop working relationships, including the attendance of community workers at appointments and at case conferences with their patients. It is preferable to encourage and educate these agencies to work with family physicians.
It is also useful to strengthen connections with your emergency room(s) and with the local department of psychiatry. Make them aware of what you are doing, and negotiate to facilitate admissions and consultations. My experience has been that it is useful to make connections with specific clinics, such as mood disorders, psychogeriatrics, child and adolescent and developmental disabilities. These allow me to obtain advice or consultation when I need it. In one of the rural clinics where I work, we are developing telepsychiatry services for just this purpose.

Small and rural communities facilitate this process effectively: most of the agencies and their workers already know each other. These agencies welcome the opportunity to work with a visiting psychiatrist, and in many cases, they already have close ties with family physicians and their staff.

**Teaching and Learning Opportunities**

An environment that consists of a psychiatrist, several GPs and other mental health care workers is one that is rich with opportunities for teaching and learning. Lunchtime, case-based learning sessions are easy to arrange. Hallway consultations are a useful way for both a psychiatrist and a GP to ask questions and share information. I have been invited to several McMaster learning groups and have found them delightful and informative and a great opportunity to teach and talk about collaborative care.

I hope that, as medical schools become more informed about their role in the community, there will be increasing opportunities to have medical students and residents visit shared care settings as part of their experience in psychiatry. This is already happening in several centres across Canada.

**Summary**

Collaborative initiatives with family physicians and community mental health teams in primary care settings are not difficult to create. Besides, they are financially feasible for both psychiatrists and GPs in several different payment schemes. They require good communication with some upfront and ongoing planning and evaluation. They are rewarding and provide an opportunity for collegiality and for the development of improved functioning for many of the disciplines that provide community mental health care.

**Suggested Readings**


**FIRST ANNOUNCEMENT**

4th National Shared Mental Health Care Conference
Halifax NS June 21–22, 2003

Focus will include expanding the reach of collaborative care, interdisciplinary issues, and services for marginalized groups

**Information:** Donna Fraser dlfraser@sprint.ca; fax 902 425 5884