Greater attention is now being focused on the family physician’s role in providing mental health care. As many as 40 per cent of individuals seen in primary care have identifiable mental health problems (1), and family physicians are often the first point of contact with the mental health system (1,2). Data from the mental health supplement to the 1990 Ontario Mental Health Survey revealed that 35 per cent of individuals will receive mental health care from their family physician only (compared with 40 per cent only in the specialized sector), even though the severity and duration of these problems are similar to those of individuals being seen in the specialized sector (3).

Despite family physicians’ key role in delivering mental health care, many problems have been identified in relationships between mental health and primary care services. Craven and others examined the issue using family physician focus groups in seven Ontario communities (4); in these groups, family physicians identified the lack of communication and personal contacts with their colleagues in psychiatry and their patients’ lack of access to mental health services as significant problems. They also felt that their role as mental health care providers was not respected or supported. The separation of family physicians from other mental health care providers is often reinforced by provincial planning initiatives that offer little connection between primary care and mental health reforms, although this may slowly be changing.

Many studies have commented on the desirability of improved collaboration between mental health and primary care services from the perspectives of both the patient and the health care provider (1,5–8). Over the last five years, an increasing number of initiatives have attempted to strengthen the relationship between these two potentially complementary specialties (9). Proponents of increased collaboration believe that it would enhance the work of both disciplines and lead to better treatment outcomes.

An often-neglected starting point for exploring ways to improve mental health services is to ask family physicians about their satisfaction with existing services (10,11) and about ways to improve them. This can assist mental health services to better meet patient needs (12–14).

Survey Goals
This survey was conducted by the Hamilton Regional Psychiatry Program, a body that co-ordinates local mental health service activities. It aimed, first, for a greater appreciation of family physicians’ (the major referral source) views of the way mental health services operated and the improvements required and, second, to use this knowledge to develop a more collaborative approach to planning and delivering mental health services.

Methodology
The current study was undertaken in Hamilton, Ontario, a community of 460,000 people with approximately 300 full-time equivalent family physicians and a lengthy history of productive collaboration between mental health and primary care services. Physicians were asked about their current level of satisfaction with the mental health services available to their patients and about ways in which these could be improved.

The survey comprised 114 items related to local services. Eight inquired about demographic information, 83 about satisfaction with services, 12 about use patterns and 11 about improvements required. Respondents were asked to rate their satisfaction with current services (specifically, emergency, inpatient, general outpatient and specialized outpatient services for children and the elderly) on a seven-point Likert Scale ranging from one = “completely unsatisfied” to seven = “completely satisfied.” They were then asked to comment on several suggestions for possible improvements to services, some of which had already been piloted by local services. Space was also included for free-text comments. Respondents were asked about their age, sex and years in practice; they were also asked to estimate the number of their patients who had used mental health services over the previous six months. The questionnaire was pilot-tested for face validity with five
local family physicians. Data were analyzed using SPSS 8.0 (15).

Names of family physicians were generated from three sources: current lists of family physicians affiliated with the two local hospital corporations, listings in the telephone book, and the medical directory list of family physicians practising in Hamilton.

Family physicians were eliminated if they were retired, had moved out of the area or were not currently working in primary care. In total, 285 family physicians were contacted; the initial letter was followed up after six weeks with a second copy of the survey and a reminder letter. Four weeks later, all nonresponders were contacted by telephone and asked to return their survey either by mail or fax. No incentives were provided for completing the survey.

**Results**

**Respondent Characteristics**

Surveys were received from 147 family physicians (52 per cent response). Of respondents, 63 per cent were men, and 37 per cent were women. Respondents had been in practice in Hamilton for a mean of 18 years, and the average estimated practice size was 2,000 (SD 750). Fifty-three per cent of respondents worked in capitation models (that is, a Health Service Organization [HSO]), all of which had mental health counsellors and psychiatrists attached to their practices (16). This group was over-represented in the sample, since only 40 per cent of local family physicians worked in HSOS. Of respondents, 40 per cent worked on a fee-for-service basis, compared with 58 per cent of local family physicians; seven per cent worked in community health centres (CHCs), compared with only three per cent of all local family physicians.

**Referrals in the Previous Six Months (Table 1)**

Referral rates to outpatient services were relatively low. On average during the previous six months, each family physician referred four cases to an emergency service and three to an outpatient service. They referred approximately three cases to children’s services, three to geriatric service and three to private psychiatrist; two cases were referred to an addiction service and 0.75 of a case to case management services. Each physician had an average of 2.5 cases admitted to an inpatient unit during this time. Physicians with a mental health counsellor working in their office referred an average of 23 cases to a mental health counsellor during that time.

**Satisfaction with Current Services (Table 2)**

The highest level of satisfaction occurred when a mental health counsellor and psychiatrist worked in the family physician’s office (an arrangement available only to those family physicians working in a capitation model); respondents rated this time at 6.29 out of seven. The highest rating was reported for inpatient services, at 4.78. Other services ratings ranged from 4.55 (geriatric psychiatry services) to 4.17 (case management services).

Children’s services rated the highest level of dissatisfaction, at 3.29.

For each of these services and for the system overall, physicians were asked to rate their satisfaction with 6 key process variables: the availability of information on existing services, intake procedures, waiting periods, communication with the family physician after patient seen, ongoing treatment update to family physician, and family physician involvement in discharge planning. These findings are summarized in Table 3. The major concern was with length of waiting times for service.

When physician and practice characteristics were examined to see whether they affected overall satisfaction, sex, medical school attended and practice size were not found to significantly affect family physician satisfaction. Family physicians who had been in practice for more than 20 years were more likely to be satisfied with mental health services. There was, however, a significant difference in overall satisfaction between physicians who had mental health services in their office (81 per cent satisfaction rating) and those who did not (56 per cent satisfaction rating) ($P < 0.05$).

**Problems Encountered Frequently**

Family physicians were also invited to write additional comments in any section of the survey. Of 147 respondents, 61 wrote additional comments. Consistent problems identified (by at least 50 per cent of respondents) included the following:

1. **Referral.** Family physicians found it more difficult to refer to psychiatry than to other specialties. They felt intake processes were neither consistent nor efficient and wondered whether a single central body is needed to co-ordinate all intakes.

2. **Communication.** Family physicians felt that communication should be more timely and complete, with a more collaborative approach.

3. **Access or Wait Times.** Family physicians identified the need for shorter waiting lists and mentioned specific gaps...
Any other improvements

Family physicians were asked to assess the benefits of specific suggestions for improving mental health services for their patients. They felt the most useful would be a listing of private psychiatrists indicating their interests and availability, followed by telephone access to a psychiatrist and psychiatrist visits to their office for clinical consultation (see Table 4).

Other suggested improvements (with at least three physicians making each suggestion) included more information about mental health services in Hamilton; backup for family physicians willing to take on the long-term care of individuals with a serious mental illness; greater availability of long-term psychotherapy, including marital counselling; and more accessible and available services for children and adolescents.

Discussion

These findings reinforced findings from previous studies and other jurisdictions (3). Overall, family physicians were not particularly dissatisfied with mental health services. Those family physicians who had access to mental health services in their office had a significantly higher level of satisfaction than those who did not. In general, however, family physicians felt that mental health services were not as accessible as they should be and that waiting times for services should be shorter. This is consistent with other surveys reporting that family physicians are relatively satisfied with the quality of services but concerned about their availability and waiting times (10,11,14). Physicians in the current survey identified that communication should be improved to ensure more rapid and efficient transfer of information after a consultation or treatment. They also felt that intake processes for mental health services needed to be more consistent and less time-consuming.

Respondents in this survey identified the benefits of having mental health counsellors and psychiatrists working in their offices. Not only did this improve communication,
co-ordination of care and access to treatment, it also led to a much higher level of satisfaction with mental health services in general.

The most useful supports identified were increased knowledge of private psychiatrists’ availability and telephone access to a psychiatrist, followed by opportunities for psychiatrists to visit family physicians’ offices. Providing information to assist family physicians in learning about local resources could be seen as a collective responsibility on the part of mental health services.

The concerns expressed about access are important and may reflect different understandings of the way mental health services could operate. While mental health services like to maintain their autonomy with separate intake procedures, family physicians clearly state that a single point of access would make referring much easier for them and for their patients.

In this study, family physicians commented positively on being asked to provide input on their views of how local mental health services were organized, but frequently added that they hoped such a survey would lead to changes. This highlights the need for mental health services to be willing to listen to the views of family physicians, their largest source of referrals, without feeling unnecessarily defensive. This kind of methodology could be easily incorporated into other mental health planning initiatives. Implementing suggestions raised in this process should lead to a productive working partnership, with mental health services being better equipped to respond to the needs of family physicians.

Survey Follow-Up
All the services included in the survey received details of specific family physician comments pertinent to their service. Services have recognized the need to respond to these comments, either by contacting family physicians to obtain more information on how to make the service more helpful or by changing their intake policies. The Hamilton Regional Psychiatry Program has also produced an updated guide to local services for family physicians; it is problem-based and has relevant information about making referrals and about available services. Psychiatric services are currently exploring how to provide telephone backup to family physicians in the community.

Conclusion
In this survey, family physicians were relatively satisfied with mental health services in their community but identified specific concerns regarding some aspects of service delivery, including communication, waiting times and their lack of involvement during treatment. It is important that mental health services pay attention to these comments arising from their major referral source and consider ways to bridge the communication gap and to make their services more accessible. One way that is appreciated by family physicians is to integrate mental health services into family physician offices. Family physicians want more information on existing services and more support in their role as mental health care providers. Further, they want improvements in services for children and adolescents and for family and couple problems. This survey also highlights the importance of soliciting family physician views on service planning and of ensuring that any suggestions made are incorporated in future mental health planning.

References

Table 4 Improvements suggested by family physicians

<table>
<thead>
<tr>
<th>Improvement suggested</th>
<th>Importance (1 = unimportant, 7 = very important)</th>
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<tbody>
<tr>
<td>Listing of private psychiatrists indicating their interests and availability</td>
<td>6.1</td>
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<tr>
<td>Telephone access to a psychiatrist</td>
<td>6.0</td>
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<tr>
<td>Visits to the office by a psychiatrist for clinical consultation.</td>
<td>5.7</td>
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<tr>
<td>Standardized intake form across the mental health system</td>
<td>5.7</td>
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<tr>
<td>Circulation of key articles</td>
<td>5.5</td>
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<tr>
<td>Visits to the office by a psychiatrist for case discussion</td>
<td>5.4</td>
</tr>
<tr>
<td>Joint rounds</td>
<td>5.1</td>
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<tr>
<td>Visits to the office by a psychiatrist for educational discussions</td>
<td>4.8</td>
</tr>
<tr>
<td>Workshop for family physicians about local services</td>
<td>4.7</td>
</tr>
<tr>
<td>Mental health worker accompanying patient to physician’s office for final visit</td>
<td>2.7</td>
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<tr>
<td>Consultation through the Internet</td>
<td>2.4</td>
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