Mental Health Practices of Ontario Family Physicians: A Study Using Qualitative Methodology

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Objective: To obtain descriptions of how family physicians detect and manage mental health problems commonly encountered in their practices and how they function in their role as mental health care providers. Also, to elicit their perceptions of barriers to the delivery of optimal mental health care.

Method: Focus groups with standardized questions were used to elicit descriptive data, opinions, attitudes, and terminology. Convenience samples of 10 to 12 physicians were chosen in each of Ontario’s 7 health care planning regions, with a mixture of rural, urban, and university settings. Discussions were audiotaped, transcribed, analyzed, and recurring themes were extracted.

Results: Family physicians’ descriptions of the range of problems commonly encountered and their detection and management highlight the unique nature of mental health care in the primary care setting. The realities of family medicine, the undifferentiated nature of presenting problems, the long-term physician–patient relationship, and the frequent overlap of physical and mental health problems dictate an approach to diagnosis and treatment that differs from mental health care delivery in other settings. Difficulties in the relationship with local psychiatric services—accessing psychiatric care (especially for emergencies), poor communication with mental health care providers, and cumbersome intake procedures of many mental health services—were consistently identified as barriers to the delivery of optimal mental health care.

Conclusions: This study confirms the importance of the family physician in the detection and management of mental health problems. It offers insights into how family physicians function in their role as mental health care providers and how they deal with diagnostic and management challenges that are specific to primary care. It also identifies barriers to the optimal delivery of mental health care in the primary care setting, including difficulties at the clinical interface between psychiatry and family medicine. Further studies are needed to explore these issues in greater depth.

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Key Words: mental health care, role of the family physician, relationship between family medicine and psychiatry

Thirty percent of all family practice patients may have significant psychosocial or psychiatric morbidity (1–6), and more than half of all patients with psychiatric diagnoses are cared for exclusively in the primary care setting (7,8). The Mental Health Supplement of the Ontario Health Survey reported that 19% of Ontarians aged 15 to 64 had one or more mental disorders in the 12 months preceding the survey and that the family physician or general practitioner was the most common source of help (9). These findings underscore the importance of the family physician in the detection and management of mental health problems. As Ontario’s mental health policy and funding continue to shift from an emphasis on institution-based care to community-based care, the role of the family physician is likely to become more prominent.

Internationally, the importance of the family physician’s role has been recognized by a number of initiatives: 1) the World Health Organization (10) has published a document that outlines policies and recommendations for increasing the delivery of mental health care in the primary care setting; 2) the United States Department of Health and Human Serv-
ices has published clinical practice guidelines for the detection and treatment of major depression in primary care (11); and 3) recently, the Royal Colleges of General Practitioners and Psychiatrists in the United Kingdom have published guidelines for the development of models of shared care (12). These documents reflect a shift of responsibility for mental health care into the primary care sector and a need for strategies to make it work.

While many studies (13–21) have addressed the family physician’s role in the management of mental health problems, their usefulness to planners, policy makers, and educators has often been limited by a lack of detail to permit adequate description of the content of mental health visits. Moreover, few of the studies report meaningful involvement of family physicians in the design of instruments or methodology, which may have limited the extent to which the data items chosen accurately represent what family physicians do. Achieving a consensus about how to define and describe the mental health interventions of family physicians is a necessary first step in the process of quantifying, evaluating, or determining the cost of the care they provide. The present study is a first step in this direction.

Purpose of the Study

The purpose of this study was to obtain descriptions of how family physicians detect and manage mental health problems commonly encountered in their practices, with particular emphasis on how they implement mental health care interventions. The study also sought to elicit family physicians’ perceptions about barriers to the delivery of optimal mental health care in the primary care setting.

Methodology

Focus group methodology was used to elicit descriptive data, opinions, attitudes, and terminology. Sites for focus groups were chosen in each of Ontario’s 7 health regions. These included small communities in the north and south of the province, 2 communities with a medical school, one community with a regional psychiatric referral centre, and 2 communities with provincial psychiatric hospitals. A pilot focus group was held to ensure that the design was feasible, to fine-tune the research questions, and to develop a method of recording and analysis.

Recruitment of family physicians for each focus group began with identification of a key informant, who was considered to be a leading figure in family medicine in that community. This person was then asked to invite 10 to 12 family physicians who had been in community practice for 5 years or more and had expressed interest in psychosocial problems and mental health care delivery. Groups were balanced for gender and certification status.

To ensure consistency, the authors (MC or MAC) facilitated or cofacilitated all the groups except one. Each group was asked:

- What kinds of psychosocial and mental health problems do family physicians see in the course of their work?
- Once they have identified a problem, how do family physicians decide whether to intervene?
- What kinds of mental health services do family physicians deliver? How do they describe and define what they do?
- How do they deliver these services?
- What kinds of things make it difficult for family physicians to deal optimally with the psychosocial and mental health problems of their patients?

Discussions were audiotaped. The tapes were transcribed and analyzed using standard qualitative methods. Recurring themes were extracted and summarized. Representative quotes are used to illustrate frequently expressed beliefs and attitudes. These are presented below.

Results

It was relatively easy to identify opinion leaders in each community and to recruit their support. In all groups but one, the participation rate was 80% or higher of those invited. The number of participants ranged from 4 to 12, and the mean was 8. The average length of each focus group was 90 minutes.

Prevalence of Mental Health Problems in the Practices of Ontario Family Physicians

There was agreement across all of the groups that caring for the mental health needs of patients is a major part of the family physician’s job. In all of the focus groups, psychosocial and psychiatric problems were described as very common. Identification and management of these problems were universally reported as consuming 25% to 50% of family physicians’ time.

The Range of Mental Health Problems Encountered by Family Physicians

When asked to list the most common types of mental health problems they see, the physicians’ responses in all focus groups were very similar. Depression and anxiety were cited as very prevalent by all the groups, as was marital dysfunction. In several cases, family physicians described anxiety and depression as the “presenting” problems, but emphasized that they were secondary to a wide variety of underlying problems, particularly childhood abuse. “They present with anxiety or depression, sometimes with some other acute life crisis, which, when you talk about it, their reactions seem out of proportion and you talk to them about their past, and psychological, physical, or sexual abuse comes out,” stated one family physician.

In the child and adolescent age group, behaviour problems were frequently mentioned, along with eating disorders, drug abuse, and unplanned pregnancies. Virtually all family physicians cared for patients with dementia, somatization disorder, alcoholism, bipolar disorder, and chronic schizophrenia. Often, they were the patient’s only mental health provider.
Family physicians frequently commented on the difficulties posed by the undifferentiated character of problems in family practice and the frequent overlap between physical and emotional problems. They also emphasized the need for a high index of suspicion to optimize detection of mental health problems. “Last week I must have had 5 people in the 2 days that I was working in my office who came in with little minor complaints and then were in major tears and their lives were falling apart,” said another family physician.

**Use of Psychotropic Medication**

Most family physicians were comfortable dealing with major depression and prescribing antidepressants. Some physicians talked about the difficulty of deciding whether to treat less severe depression. One family physician described how “sometimes it is very clear-cut or you know the symptoms all fit in the textbook way and you don’t have any reservations about using medication. There are other cases where it is not so clear-cut, and those are the people that I find I take a little bit more time to meet with them more often and I will let the patient help me decide.”

Most family physicians indicated that they would start medication based on their evaluation of the patient’s history and presentation at the time of the initial visit. A few indicated that they would schedule a return appointment to see whether there had been any improvement in symptoms and to address psychosocial stressors. Most stated that they would schedule a follow-up visit when they had prescribed antidepressant medication. The time interval between the first and second visit varied widely, however, from the following week to 5 to 6 weeks because, in the words of one family physician, “it takes that long for the drug to work.” Some family physicians commented on the need for pharmacological intervention to occur before the patient was ready for counselling.

With the exception of one northern site, where the family physicians initiated prescriptions for antipsychotic medications fairly regularly, most family physicians were only involved in monitoring these drugs. Antipsychotic drugs were prescribed with reservation by most family physicians, often as a way of stabilizing a situation and occasionally as a substitute for counselling or psychotherapy.

A number of family physicians commented on their role in monitoring medications started by psychiatrists and the difficulties posed by the lack of appropriate information and backup. For example, one family physician complained “sometimes I’ve never used the drug before. Psychiatrists like to use whatever’s new and then expect us to be OK with it.”

**Management of Psychosocial Problems**

Time constraints and the sheer volume of demand were cited as important factors in whether a family physician pursued suspicions that a psychosocial problem was present. “I think people joke about it,” said one family physician, “but you actively think ‘Should I ask the question?’ You know if you ask the question, you’re going to take the lid off it.”

Level of subjective distress, the patient’s ability to function, and whether the patient and his or her family are “safe” were frequently cited as factors that determined whether the family physician would pursue a psychosocial problem immediately, bring the patient back, or refer him or her elsewhere. “You have to decide who’s most in trouble,” one physician said, “and that’s who I focus my energy on. I refer one out of 20 of the cases I see. I can’t help everyone.”

The ability to judge degree of distress, based on prior knowledge of the patient and his or her family, was cited as one of the strengths of the family physician: “one advantage of being a family doctor is you do see the patterns over time, and you can pick up that pattern when you see this kind of going-down period.”

There was a strong consensus that crises required immediate attention and should receive the same degree of concern as medical emergencies. The importance of the “window of opportunity” was mentioned by several family physicians as a special situation. When a patient with a chronic or recurrent problem is finally ready to accept help, family physicians recognize the importance of responding immediately. As one family physician said: “I think most of us would find it very difficult when someone has just started to open up to . . . I find it very difficult to say ‘We haven’t got time to deal with that right now.’ No matter how nicely you put it, if that is the message, then you may well ruin everything.”

Most family physicians indicated that unexpected psychosocial or psychiatric problems played havoc with their office schedule, but they simply accepted it as the nature of family practice. Virtually all of the family physicians indicated that they would schedule a return appointment to talk in greater depth about a problem raised by a patient during a medical visit, or to monitor the level of coping in a crisis. Many also routinely set aside half- or one-hour sessions during the week for regular counselling or psychotherapy sessions with patients. The amount of time spent in scheduled counselling varied widely, but 3 to 5 sessions per week was a commonly cited range. As one family physician described, much time was also spent in unscheduled counselling: “Scheduled counselling, I probably spend only about 3 hours per week, but dealing with stuff as it comes up, I’m sure that at the end of each day I’ve billed at least an hour and a half.”

**The Process and Content of Counselling and Psychotherapy in Primary Care**

Most of the family physicians emphasized that the physical and emotional aspects of a patient’s problem frequently overlap: “You can’t take care of a patient’s cancer without dealing with the fear. It’s all mixed together.”

In addition to making the detection of emotional problems more difficult, this overlap of physical and emotional problems also has implications for investigation and management. The family physicians in our study emphasized that dealing
and knowing their weaknesses.” A third family physician also stressed the importance of recognizing a patient’s strengths and weaknesses, and using them to guide the treatment process. He explained, “I call that supportive counselling.”

The family physicians we interviewed felt that they were providing important and necessary mental health care, but questioned the appropriateness of using approaches and labels borrowed from psychiatry. When they talked about what they do to help patients, the same words and phrases tended to recur (Table 1). Although family physicians were reluctant to describe what they do as “formal psychotherapy,” they frequently used the term “supportive counselling.” Definitions for this varied widely. For example, “A person who comes to mind,” explains a family physician, “is a patient who is splitting from her husband. So I can work with them.”

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Table 1. Family physicians’ descriptions of their psychotherapeutic interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Description</th>
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<tbody>
<tr>
<td>Caring</td>
<td>Help them put things in order</td>
</tr>
<tr>
<td>A safe place</td>
<td>Help them identify the main issue</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Try to help them cope</td>
</tr>
<tr>
<td>Deal with the immediate crisis</td>
<td>Somebody they can talk to, who cares</td>
</tr>
<tr>
<td>Identifying what the problems are</td>
<td>—</td>
</tr>
<tr>
<td>Ask a lot of questions and reflect back to them [the answers]</td>
<td>Letting people get things off their chest</td>
</tr>
<tr>
<td>Exploring options</td>
<td>Give them some hope</td>
</tr>
<tr>
<td>Acknowledging [their stress]</td>
<td>Make sure they’ve felt listened to</td>
</tr>
<tr>
<td>Making it legitimate [to feel the way they do]</td>
<td>Help with decision making</td>
</tr>
<tr>
<td>Letting them know it’s OK to talk about themselves in some way</td>
<td>[Help them] to feel positive about</td>
</tr>
<tr>
<td>Empathy</td>
<td>Help them change their behaviour</td>
</tr>
<tr>
<td>Reassurance</td>
<td>Try for little increases in assertiveness</td>
</tr>
<tr>
<td>Support</td>
<td>Using their strengths and knowing their weaknesses</td>
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with comorbid physical and emotional problems requires a flexible, patient-centred approach to care, with frequent shifts of focus between physical and emotional symptoms, and integration of physical and mental health interventions. This makes it difficult to describe family physicians’ mental health interventions in terms of traditional psychiatric treatment processes. Furthermore, family physicians were reluctant to use the terminology of psychiatry and psychology. As one physician explained, “I don’t consider myself an expert in psychotherapy. I don’t consider myself someone who provides expertise in that area. But I do consider myself fairly empathetic and compassionate and have had enough life experience, hopefully, at this stage, that I can listen to them and I can work with them.”

The family physicians we interviewed felt that they were providing important and necessary mental health care, but questioned the appropriateness of using approaches and labels borrowed from psychiatry. When they talked about what they do to help patients, the same words and phrases tended to recur (Table 1). Although family physicians were reluctant to describe what they do as “formal psychotherapy,” they frequently used the term “supportive counselling.” Definitions for this varied widely. For example, “A person who comes to mind,” explains a family physician, “is a patient who is splitting from her husband. So I guess what would be covered by supportive counselling [in this case] is ‘How is the mental health of the kids? Do you have access to legal advice? Do you feel that reconciliation is a possibility? Are you eating? Are you sleeping?’” Assess them for depression and suicidal ideation. And bring them back. I call that supportive counselling.”

Another physician explains: “I would sometimes say it is exploring options, you know, bouncing ideas back and forth, and a lot depends on the person. But there again, it comes back to what we know about that person, using their strengths and knowing their weaknesses.” A third family physician emphasized his role in normalizing patients’ reactions to stressful situations: “I think it’s an acknowledgment. If somebody is in a stressful situation and you say, ‘Boy, you’re in a stressful situation, it is no wonder you feel like this,’ they may feel better just hearing it’s a normal sort of response.”

Barriers to Optimal Mental Health Care: The Current Relationship Between Family Medicine and Psychiatry

Five of the 7 groups of family physicians identified lack of psychiatric consultation and backup as a major issue. The other 2 groups, one rural and one northern, indicated that they had been functioning without psychiatric resources for so long that they no longer expected them. They dealt with most psychiatric problems as best they could and used local counselling services extensively. Their acceptance of the status quo was not typical of the majority of physicians.

As one physician recounts: “I find that in an acute situation, it is very difficult to get a psychiatrist on the phone or a psychiatric resident or someone who will willingly assess that patient . . . or the clinic says ‘It’s not our region.’ Or ‘We’ll have the intake worker call you.’ And they never call. So the whole problem stays on your head and you spend the whole weekend worrying and thinking ‘How will I sort this out?’”

Many family physicians also expressed frustration about psychiatrists’ lack of confidence in family physicians’ assessment skills: “And then they don’t really believe you. ‘Are you sure they’re suicidal?’” And there’s this overtone of the resident telling us ‘You’re not psychiatrists. You don’t really know what you’re talking about, and you don’t really know this patient and so you are wasting my time on somebody who has really not got a problem.’” Family physicians emphasized that access to timely consultation was not a problem with any other specialty. Ironically, having a large population of psychiatrists does not necessarily guarantee ease of access. In one urban centre, where the number of psychiatrists was perceived to be more than adequate, family physicians expressed frustration and anger at their difficulty in getting their patients seen.

In another, smaller urban centre, the family physicians were angry that local psychiatrists refused to have hospital privileges, effectively leaving all acute care of hospitalized suicidal, homicidal, or psychotic patients to the family doctor, with no psychiatric backup at night or on weekends. Although they have access to an Ontario psychiatric hospital some distance away, they refer only the most serious and unstable patients there because, as a physician explained, “it takes a half day on the phone to get someone admitted.”

Barriers: Family Physicians’ Use of Ontario Health Insurance Plan (OHIP) Billing Codes

Many family physicians identified billing issues as problematic. They consistently reported concern that billing codes failed to recognize the overlap between medical and mental health care. They also believed that the OHIP billing guidelines (22) did not take into account the practical issues in-
involved in the delivery of mental health care in the primary care setting. Several family physicians indicated that there was a need for a new code that would better reflect the types of mental health interventions provided by family physicians and would not be rigidly tied to 20-minute time blocks.

Limitations of the Study

1) As the sample used was a convenience sample of practising family physicians, our results cannot necessarily be generalized to all family physicians in Ontario. The similarity of findings from focus groups held in widely divergent geographic settings, with a wide range of psychiatric and community mental health resources, however, suggests that similar findings might be obtained in a more extensive study. 2) As participants in focus groups usually had significant experience in managing mental health problems, their discussions may not include some issues relevant to family physicians who are less experienced or less interested in mental health care. 3) The family physicians’ comments are subjective. No attempt was made to validate their perceptions through chart review, patient interview, or direct observation. The high degree of consistency in the reporting of family physicians across the 7 locations, however, suggests that what they report is likely to correlate reasonably well with what they do.

Discussion

The results of our province-wide focus groups with family physicians are consistent with previous studies (1–6) on a number of points. Our participants reported high levels of psychosocial and psychiatric morbidity in their practices and consider it an important part of their job to deal with these problems. As in other studies (15,23,24), these family physicians see a wide range of psychiatric and psychosocial problems, with depression, anxiety, and marital problems occurring most frequently.

Depressed patients who present with physical symptoms can be more difficult for primary care physicians to recognize and diagnose (25–28). This finding was confirmed by the family physicians we interviewed, who indicated that the undifferentiated nature of their patients’ presentations was a major challenge for them. They reported considerable difficulty in sorting out the respective contributions of physical problems, adverse life events, and psychiatric disorders to a patient’s presentation. Future studies should focus on the family physician’s approach to the complex, undifferentiated patient, and how identification of mental health problems can be optimized in the primary care setting.

The large volume of psychosocial and psychiatric problems encountered by family physicians was also an issue. The family physician’s ability to determine which problems can and should be addressed is central to good care and to optimal use of health care resources. Unlike most other mental health providers, family physicians do not have the luxury of knowing when a patient with a mental health problem will appear in their office or what the nature of the problem will be. Several times a day, a family physician must make immediate decisions about whether to pursue a problem, defer it, or refer it elsewhere. The family physicians in our study described a number of factors that influenced their decisions. These included level of symptom acuity, degree of risk, the physician’s confidence in his or her skills, previous successes with similar problems, competing demands of other patients, the quality of a patient’s support system, and the availability of community resources. These decision-making processes and factors affecting them require further study.

Some consistent themes emerged regarding the use of psychotropic medications. These physicians felt comfortable using antidepressants and often combined antidepressants and psychotherapy. Unlike physicians in a 1993 survey by Matthews and others (29), they did not report difficulty in selecting an appropriate antidepressant. This may reflect the increasing popularity of selective serotonin reuptake inhibitors. We noted wide variation in family physicians’ practices in monitoring patients who were on antidepressants, however; this is a finding that deserves further exploration.

Several family physicians reported difficulty in deciding whether to start antidepressant medication in patients who were less severely depressed. This is consistent with, and may help to explain, reports in the literature that family physicians tend to undertreat depression (19,30–32).

The physicians in the study reported frequent utilization of psychotherapy and counselling as treatment interventions. The literature on the frequency of psychotherapy and counselling by family physicians is limited and inconsistent. The United States National Ambulatory Care Survey of 1991 (33) found that only 5% of all ambulatory primary care visits included psychotherapy or mental health counselling. In contrast, a national survey of American family physicians (24) found that 73% reported providing psychotherapy “frequently” or “very frequently.” In a recent mail survey of Ontario family physicians (21), 88% of respondents reported one or more half-hour psychotherapy sessions per week, with 59% reporting between one and 5 sessions. In the focus groups, physicians made a clear distinction between prebooked psychotherapy sessions, which they provided an average of 3 to 5 times per week and the much more frequent “informal” psychotherapeutic interventions, which they implemented during visits for physical problems.

While other mental health care providers usually do psychotherapy in prearranged, purpose-, and time-specified treatment sessions, family physicians frequently conduct informal psychotherapy in unscheduled, time-pressured visits that have another agenda. For example, the healthy baby check, which turns into a discussion of a mother’s marital problems or the Pap smear that leads to disclosure of childhood sexual abuse. If significant psychosocial problems are uncovered, the focus of the visit will shift accordingly. This approach does not fit standard concepts of formal psychotherapy. The distinction between formal and informal psycho-
therapy, as practised by family physicians, deserves more attention. If informal psychotherapy occurs in response to the needs of patients and reflects the philosophy and practical demands of family medicine as a specialty, it should be formally recognized and studied. Are family physicians delivering a valuable service with important positive effects on patients’ mental and physical health? Can their interventions be shown to be cost-effective? These and other questions need to be addressed.

The family physicians identified a number of barriers that they felt interfered with the delivery of optimal mental health care. Of particular relevance to psychiatry were consistent complaints about the working relationship between family physicians and psychiatrists. It was striking that none of the groups felt that they had good access to psychiatric consultation, advice, and backup. Even in centres with a large number of psychiatrists, family physicians complained of multiple, frustrating barriers to access and contrasted this to the ready access they had to other specialists. Ironically, urban family physicians often expressed more frustration and anger than physicians working in small towns and rural areas, who had often become resigned to poor access to psychiatric assistance. Many physicians, particularly those in urban centres, described lack of collegiality, lack of respect from psychiatrists for their assessments of patients, reluctance on the part of psychiatrists to take urgent referrals, and difficulty getting telephone advice. These findings contradicted a recent study by Swanson (21) that found 75% of family physicians surveyed could obtain psychiatric consultation for an acute problem within 24 hours. They are consistent, however, with an earlier study conducted in Hamilton–Wentworth (34). In a series of focus groups across that region, family physicians complained of poor communication between family medicine and psychiatry, difficulty in accessing timely psychiatric consultation and backup, cumbersome and inefficient intake procedures in many psychiatric clinics, and limited support for their role as mental health caregivers.

The similarities between the findings of the earlier Hamilton–Wentworth study and the current province-wide study are striking: nor is this a problem specific to Ontario. Fisher (35) surveyed 360 American family physicians and found that 49% were dissatisfied with the feedback received from psychiatrists and other mental health professionals. Orleans and others (24) found that 33% of 350 American family physicians surveyed cited lack of coordination and collaboration with the mental health care provider as a reason for avoiding referral. Watters and others (36) surveyed 40 Irish family physicians and found that 53% felt they were not adequately informed about their patients by psychiatrists. These findings suggest that the current relationship between psychiatry and family medicine would benefit from closer scrutiny and a reappraisal of the roles and responsibilities of family physicians and psychiatrists and how they work together. As health care systems are restructured, family physicians are likely to assume more responsibility for the care of patients with difficult and complex mental health problems. This requires adequate access to support and backup from psychiatrists.

Virtually all the physicians interviewed agreed that current provincial insurance plan billing codes (22) underrepresent the amount of mental health care delivered by family physicians. They also discourage brief, unscheduled counselling and psychotherapy when patients disclose psychosocial problems during a medical visit. Similar findings have been quoted by Swanson (21). If family physicians are delivering a service that meets the needs of patients, it should be recognized and appropriately supported.

Conclusions and Implications for Future Research

This study confirms the importance of the family physician in the detection and management of mental health problems. It identifies a number of diagnostic and management challenges specific to primary care, and it offers some insights into how family physicians deal with these challenges and how they deliver mental health care. It also identifies significant deficits in the relationship between family medicine and psychiatry, which are perceived by family physicians to have a negative effect on their ability to deliver optimal mental health care. Future studies should explore in greater depth the diagnostic and management issues raised in this study and should address problems identified at the clinical interface between psychiatry and family medicine.

Clinical Implications

- Family physicians play a key role in mental health care delivery.
- Characteristics of primary care affect how mental health care interventions are delivered by family physicians.
- Problems exist at the clinical interface between psychiatry and family medicine.

Limitations

- The convenience sample limits confidence in the generalizability of the findings.
- Our sample was biased toward family physicians with an interest in mental health care.
- There was a lack of objective validation of mental health care activities reported by family physicians.

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References

Résumé

Objectif : Obtenir des descriptions sur les méthodes utilisées par les médecins de famille pour déceler et traiter les problèmes de santé mentale qu’ils observent fréquemment chez leurs patients et sur la façon dont ces médecins s’acquittent de leur rôle de dispensateurs de soins psychiatriques. Également obtenir leurs vues sur les obstacles à la prestation de soins de santé mentale optimaux.

Méthode : Des groupes de discussion auxquels ont été posées des questions normalisées ont été utilisés pour obtenir des données descriptives ainsi que des informations sur les opinions, les attitudes et la terminologie. Des échantillons de commodité formés de 10 à 12 médecins ont été choisis dans chacune des 7 régions de planification des soins de santé de l’Ontario, en assurant une représentation des milieux ruraux, urbains et universitaires. Les discussions ont été enregistrées, transcriées, puis analysées, et les thèmes récurrents ont été isolés.

Résultats : Les descriptions fournies par les médecins de famille, sur l’éventail des problèmes observés fréquemment et les méthodes utilisées pour le dépistage et le traitement, font ressortir le caractère unique de la prestation des soins psychiatriques dans le secteur des soins primaires. Les réalités de la médecine familiale, la nature non différenciée des problèmes qui se présentent, la relation à long terme qui s’établit entre le médecin et son patient, ainsi que le chevauchement fréquent entre les problèmes de santé physique et mentale, commandent l’adoption d’une approche en matière de diagnostic et de traitement qui diffère de celle utilisée pour la prestation des soins psychiatriques dans d’autres contextes. Les difficultés à établir des liens avec les services locaux de psychiatrie — accès aux soins psychiatriques (en particulier en cas d’urgence), piètres communications avec les dispensateurs de soins psychiatriques et lourdeur des procédures d’admission dans bon nombre de services psychiatriques — ont à maintes reprises été citées comme obstacles à la prestation de soins optimaux de santé mentale.

Conclusion : La présente étude confirme l’importance du médecin de famille dans la détection et le traitement des problèmes de santé mentale. Elle fournit en outre des précisions sur la façon dont les médecins de famille exercent leur rôle de dispensateurs de soins psychiatriques et sur les méthodes de diagnostic et de traitement spécifiques au domaine des soins primaires. Elle identifie également les obstacles à la prestation optimale des soins de santé mentale dans le secteur des soins primaires, y compris les difficultés qui existent au niveau de la relation clinique entre la psychiatrie et la médecine familiale. D’autres études devront être menées pour étudier ces questions plus à fond.