Sharing Care: The Psychiatrist in the Family Physician’s Office

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Objective: One way of strengthening ties between primary care providers and psychiatrists is for a psychiatrist to visit a primary care practice on a regular basis to see and discuss patients and to provide educational input and advice for family physicians. This paper reviews the experiences of a program in Hamilton, Ontario that brings psychiatrists and counsellors into the offices of 88 local family physicians in 36 practices.

Method: Data are presented based on the activities of psychiatrists working in 13 practices over a 2-year period. Data were gathered from forms routinely completed by family physicians when making a referral and by psychiatrists whenever they saw a new case. An annual satisfaction questionnaire for all providers participating in the program was also used to gather information.

Results: Over a 2-year period, 1021 patients were seen in consultation by one full-time equivalent psychiatrist. The average duration of a consultation was 51 minutes, and a family member was present for 12% of the visits. Twenty-one percent of the patients were seen for at least one follow-up visit, 75% of which were prearranged. In addition, 1515 cases were discussed during these visits without the patient being seen. All participants had a high satisfaction rating for their involvement with the project.

Conclusions: Benefits of this approach include increased accessibility to psychiatric consultation, enhanced continuity of care, support for family physicians, and improved communication between psychiatrists and family physicians. This model, which has great potential for innovative approaches to continuing education and resident placements, demands new skills of participating psychiatrists.

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The prevalence of individuals with psychosocial distress in primary care (as measured by the General Health Questionnaire) may be as high as 40% (1–3), while the prevalence of psychiatric disorders is 25% (4–7). For many of these individuals, the family physician may be the sole provider of mental health care (8).

Despite the high prevalence, treatment rates of mental health problems in primary care are relatively low (9,10). Data from the US 1990 National Ambulatory Care Medical Survey (11) found that 5% of all family physician visits involved some form of counselling, while 5.9% involved the prescription of psychotropic medication (12). Family physicians refer fewer than 5% of individuals with an identified psychiatric illness for a psychiatric assessment or treatment (13), and even fewer (less than 1%) to a community agency (14).

Family physicians have consistently indicated that their role in delivering mental health care could be enhanced if psychiatric services were more accessible and if support or advice was more readily available. A series of focus groups held with family physicians in 7 communities across Ontario found high levels of dissatisfaction with the accessibility of timely psychiatric consultation, psychiatric treatment, and the lack of communication on the part of mental health services (15). Family physicians frequently felt their judgement was
undervalued by psychiatrists, and a lack of collegiality existed between the 2 disciplines. This is consistent with findings from other jurisdictions (16–18).

Overcoming these difficulties and establishing new productive partnerships between mental health services, psychiatrists, and family physicians require innovative models of collaboration (19–22). Such models view both primary care and specialized mental health care as important components of an integrated mental health care system, with mental health care being shared by providers with complementary roles. In these models of shared care, the patient would have easy access to specialized care when needed. Although there are many ways in which mental health care can be shared (19,22), one approach is for psychiatrists to work within the primary care setting (19–28).

Current Project

This paper reviews the experiences of psychiatrists working in the offices of 86 family physicians in 36 Health Service Organizations (HSOs) serving 170000 people in Hamilton–Wentworth, Ontario, and the lessons learned from 2 years of clinical collaboration.

HSOs are rostered primary care practices, funded by capitation, with the per capita payment being weighted according to projected service utilization. The 78 HSOs in Ontario are currently the only capitated primary care practices in Canada.

All 36 HSOs in Hamilton–Wentworth participate in a mental health program that has 2 components: 1) mental health counsellors (approximately 1:8000 patients) and psychiatrists who work within each HSO and 2) a Central Management Team, responsible for administering and evaluating the program and implementing program-wide activities.

Psychiatrists in Family Physicians’ Offices

Nine psychiatrists provide services to the 36 practices. Between them they deliver 20 half-day sessions of care each week, the equivalent of 2 full-time psychiatrist positions. A psychiatrist visits each practice every 1 to 4 weeks, depending on the practice size and need. The psychiatrists are funded by a sessional fee, which covers all their activities in the HSO. This comes from the budget allocated to each HSO for the mental health program by the Central Management Team.

Psychiatrists are expected to work collaboratively with the family physician, rather than setting up parallel activities or a separate mental health clinic in the family physician’s office. This supports and reinforces the role of the family physician as a key provider of community mental health care and avoids undermining or usurping their role.

Activities of the Psychiatric Consultant

The psychiatrist has 4 major spheres of activity: consultation, follow-up, indirect services (the patient is discussed or reviewed, but not seen), and education. He or she is also available by phone to discuss previously seen patients or to discuss new problems that arise in-between visits.

The Consultation

When in the HSO, the psychiatrist sees any case referred by the family physician or counsellor. The consultation in the family physician’s office differs in many ways from that conducted in the psychiatrist’s office. An important advantage is that the psychiatrist can discuss the problem with the family physician before the patient is seen, clarifying specific questions to be answered during the consultation. Relevant background history can be summarized efficiently, and the outcome of previous or current therapeutic interventions by the family physician or other mental health services reviewed. In most instances, family physicians have been receptive to being interrupted during a patient visit to discuss a patient the psychiatrist has seen, to write a prescription, or to provide information about a patient soon to be seen.

Following the interview, the psychiatrist provides the family physician with immediate feedback, and the psychiatrist and family physician work out a comprehensive management plan before the patient leaves. The family physician knows that the psychiatrist will be returning, usually in one or 2 weeks, and will then be able to review the patient’s progress and any problems that have arisen. The psychiatrist is also available by phone to discuss emergencies with the counsellor or family physician and work out immediate management plans. Unless a family physician is unavailable, the psychiatrist will not write prescriptions for patients he or she has seen. This ensures the family physician is directly involved in all medication decisions and is familiar with the drug being prescribed, its side effects, and possible interactions with other medications the patient is taking.

The psychiatrist handwrites consultation notes in the primary care record of that patient. In that way, all notes and recommendations are in the chart before the psychiatrist leaves and are readily available during the next contact that patient has with any provider in that practice. Notes are brief and do not repeat history already available in the chart. The most important part of the consultation notes is a point-by-point management plan, which includes advice for different contingencies. The same standards for confidentiality as would be expected by a mental health facility apply to any note sent out of a practice by a psychiatrist.

Follow-Up Visits

The psychiatrist may elect to see a patient for a follow-up visit to stabilize someone who is acutely ill, monitor the outcome of a specific intervention, or broaden the assessment to include other family members. The program’s policy is to keep follow-up visits to a minimum, as the goal of the psychiatrist is to hand back care to the family physician or
counsellor and support his or her ongoing management. In some instances, however, a follow-up visit may be an important component of short-term management or the stabilization of someone who is acutely ill.

**Case Discussions**

During a half-day visit, the psychiatrist will also review and discuss cases with the family physician or the counsellor. These discussions may be prearranged, sometimes with a single family physician, but often with all the physicians and even other primary care providers in that practice. More commonly, they are brief and more informal “corridor” contacts. These usually take less than 5 minutes and are focused, taking advantage of the limited time a family physician has between patients. A discussion may be about a new case or the progress of a patient who has already been seen or reviewed. They may deal with a medication issue, a management problem, a medicolegal issue, or community resources. They often serve to support a family physician in implementing a chosen management plan.

**Educational Interventions**

An important area of activity for the psychiatrist is providing educational input for the family physicians. Once the psychiatrist is present within the primary care setting and is meeting regularly with the family physician, opportunities arise for both case-based teaching and structured educational presentations around a topic of the family physician’s choosing. These presentations are brief and carry a simple, generalized message that can be reinforced by educational aids (hand-outs, visual reminders, or charts).

**Organization of the Visit**

Each HSO has worked out a method whereby the psychiatrist finds his or her referral forms and charts on arrival and can begin work in a designated space. Scheduling appointments is usually the responsibility of the HSO counsellor or receptionist. A separate appointment book for the psychiatrist is kept in the HSO, and any family physician or counsellor who has a patient they wish the psychiatrist to see makes the appointment and writes it in the book. Time set aside for case discussions or educational sessions with family physicians is also marked off. The psychiatrist marks any follow-up appointments in the same book. If a patient cancels at the last minute, primary care staff attempt to find a replacement consultation.

**Results**

The data presented are derived from the first 2 years of activities in the program’s original 13 HSOs (45 physicians serving 80000 patients). Data are drawn from the program’s data base, which tracks every referral to a counsellor or psychiatrist and the services each provides. Additional data come from an annual satisfaction questionnaire for all provid-

ers. During the initial year of the program, there was 0.8 of a full-time equivalent psychiatrist for the 13 practices. This increased to one full-time equivalent psychiatrist in year 2. The overall amount of time spent working in HSOs by each psychiatrist ranged from half a day a week to 2 days a week.

During the 2-year period, the program received 4993 referrals from the 13 HSOs, an average of 2497 a year or 28.8:1000 population. Of these, 1027 were referred to the psychiatrist (21% of all referrals to the program).

**Consultations**

The most frequent reason for making a referral was for advice about medication (83% of all referrals). Other reasons for a referral (more than one could be identified for each referral) included clarification or confirmation of a diagnosis (68%), advice about individual management or therapy (36%), a family or marital problem (8%), and concerns about a risk of self-harm or violence toward others (6%).

Thirty-nine percent of patients referred to the psychiatrist had already been seen by the HSO’s counsellor. In some HSOs, almost every referral to the psychiatrist was initiated by the family physician. In others, up to 90% were initiated by the counsellor after discussion with the family physician.

The counsellor was present for 35% of all consultations by the psychiatrist, and the family physician was present for 7%, although often for only a portion of the interview. Twelve percent of patients referred to the psychiatrist were seen with another family member in attendance. The average duration of a consultation was 51 minutes, although this ranged from 10 minutes to 3 hours (for one assessment of a child).

Ninety-six percent of all individuals seen were considered to have a DSM-IV diagnosis (Table 1). A psychiatrist could identify more than one diagnosis after a consultation. The most frequent diagnoses were mood and anxiety disorders, the problems with the highest community prevalence. Fourteen percent were diagnosed as having an adjustment disorder, phase-of-life, or relationship problem.

<table>
<thead>
<tr>
<th>Table 1. DSM-IV diagnosis of individuals seen</th>
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<tr>
<td><strong>Diagnosis</strong></td>
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<td>Mood disorder</td>
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<tr>
<td>Anxiety disorder</td>
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<tr>
<td>Adjustment disorder</td>
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<tr>
<td>Phase-of-life or relationship problem</td>
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<tr>
<td>Psychotic disorder</td>
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<tr>
<td>Substance abuse</td>
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<tr>
<td>Personality disorder</td>
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<tr>
<td>Attention-deficit disorder</td>
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<tr>
<td>No DSM-IV diagnosis</td>
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<td>Somatisation disorder</td>
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*A psychiatrist could identify one or more diagnoses per patient.*
In 90% of consultations, the psychiatrist made a medication recommendation (initiating, adjusting, or discontinuing a drug). In 74% of cases, he or she recommended some form of ongoing psychotherapy or counselling. This included individual (55% of all referrals), couple or family (15% of all referrals), or group (4%) treatment.

The psychiatrist also recommended a referral for follow-up to a community agency for 9% of patients, or to another mental health service (6%). Twelve percent were referred to the HSO’s counsellor for ongoing care, in addition to the 36% of patients referred to the psychiatrist who were already seeing a counsellor.

**Follow-Up Visits**

Twenty-one percent of all patients seen by the psychiatrist received at least one follow-up visit. Forty percent of these received 2 or more follow-up visits. In 75% of cases, the follow-up visit was planned in advance to monitor progress or meet with other family members. Twenty-five percent of visits occurred because of deterioration in the patient’s condition, medication side effects, or a supervening crisis.

**Case Discussions**

Over a 2-year period, 1515 cases were discussed and reviewed during the psychiatrist’s half-day visits. Fifty-five percent were discussions of patients the psychiatrist had already seen. The other 45% were new cases. Seventy percent of these discussions took place with the counsellor, 19% with the family physician, and 11% with both. The average duration of a case discussion was 10.4 minutes.

**Telephone Backup**

Program psychiatrists were also available to provide consultation or advice by phone. A study of telephone calls made by 5 practices (18 family physicians) to one psychiatrist attached to those practices found that over the course of a year 128 calls were made. The family physician considered 50 of these to be urgent, while 78 were for advice about nonurgent management or medication issues. Each call averaged 8 minutes, which meant the psychiatrist spent about 20 minutes a week responding to calls from family physicians.

**Satisfaction with the Program**

Eighteen months after the program started, a formal survey of provider satisfaction was conducted. Family physicians and psychiatrists were asked to rate their satisfaction with the program, using a 5-point Likert scale. Family physicians’ average level of satisfaction with psychiatrists (Max. 5.0) was 4.6. Psychiatrists’ overall satisfaction rating was also 4.6. All psychiatrists stated that they would recommend this style of practice to a colleague.

**Discussion**

This shared care model of consultation—liaison psychiatry appears to be feasible, well-suited to a range of practice sizes and styles, and results in a number of benefits for patients, providers, and the mental health system. These include:

1) **Increased Accessibility to Psychiatric Consultation.** A recent Canadian study of the role of family physicians in providing mental health care has identified major difficulties in access to psychiatry (16). In our program, the average full-time equivalent psychiatrist sees approximately 550 consultations a year, usually within 4 weeks of the referral being made. This is between 2 to 3 times the number of cases seen by a full-time psychiatrist working in general mental health clinics in the same community. This is possible because psychiatrists and family physicians share the responsibility for the management of a mental health problem. This also increases the likelihood that the large number of individuals with serious mental illnesses who receive no treatment during the course of a year, but do visit their family physician (8), will receive an assessment and have treatment initiated.

Removing barriers to psychiatric consultation may increase the likelihood of detection of mental health problems by the family physician. The family physician knows that if he or she identifies a problem that requires a consultation, the patient will be seen relatively quickly and by a provider with whom the family physician is personally familiar.

2) **Enhanced Continuity of Care.** In this model, the care of individuals with mental health problems or disorders is shared. The psychiatrist provides a range of services to the family physician and patient throughout a crisis or episode of an illness and remains involved until the patient’s condition stabilizes. Providers communicate with each other frequently and treatment plans are worked out collaboratively, taking into consideration the effectiveness of previous interventions and the impact of any concurrent medical conditions. Management plans are reviewed at subsequent visits and any necessary adjustments are made. The psychiatrist is available by phone in-between visits to review a patient’s progress and will reassess a patient at any time, with no administrative barriers to be circumvented.

3) **Increased Support for the Family Physician.** The collaborative approach ensures that the family physician remains involved with the care of his or her patients on a continuing basis. Management responsibilities can be allocated in a flexible manner, according to the needs of the patient and the skills and comfort of the providers. The family physician is an active participant in consultations and can provide important information about the patient’s medical and psychiatric history, interpersonal style, and family circumstances. Ease of access to advice from the consulting psychiatrist, in person or by phone, increases the family physician’s comfort in managing patients with more complex problems, whom they would have referred to psychiatry prior to the establishment of the program.

4) **Improved Communication.** Program psychiatrists spend approximately 10% of their time discussing cases or problems with the referring family physician, a higher proportion of time than is usually spent by clinicians working in traditional
mental health services. The time spent discussing a case before a consultation ensures that the psychiatrist is aware of the specific question the family physician wants answered. The time spent after a consultation ensures that the consultant, consultee, and patient are all aware of the treatment plan and their respective roles before the patient leaves. The handwritten note in the chart ensures that a permanent record of the consultation is in the family physician’s office on the day of the consultation.

5) Strengthened Contact Between Providers. As the psychiatrist and primary care provider get to know each other, their understanding of the skills of the other and the demands and limitations under which each works increases. The personal contacts also create further opportunities for informal discussions of other problems, which provides assistance to the family physician that would not otherwise be available.

6) More Efficient Utilization of Mental Health Services. Frequently, input from the psychiatrist, either through advice about management or seeing a patient in consultation, enables a family physician to continue to follow a patient who might otherwise have been referred to a psychiatric service. Patients who are admitted to hospital or who require treatment in a more specialized treatment program can sometimes be discharged earlier because of the program’s ability to assist the family physician in monitoring care or continuing a treatment plan. As a result, outpatient services are used more selectively and efficiently, with financial savings likely for the system.

7) Innovative Approaches to Physician Education. The presence of the psychiatrist and counsellor in the family physician’s office creates exciting new possibilities in continuing education. These can be based upon problems the family physician is seeing in his or her practice and tailored to the needs of each physician. The time frame (often 5- to 10-minute sessions) fits with the limited amount of time a family physician usually has during his or her day to devote to educational activities. The content of a presentation can be reinforced by handouts, relevant references, or other visual aids.

8) Valuable Experiences for Learners. This model of shared mental health care provides unique opportunities for learners from different disciplines to watch family physicians and mental health professionals work collaboratively, while learning skills relevant to their future practice. This is particularly true for psychiatry residents who have few opportunities to learn these skills in traditional ambulatory rotations (29).

New Demands of the Psychiatrist

The style of practice described in this paper demands new skills of consulting psychiatrists. The psychiatrist in primary care is truly a generalist. He or she needs to be comfortable assessing individuals of all ages with a wide variety of problems and diagnoses. The psychiatrist must also be able to conduct an efficient, focused consultation and develop an immediate management plan, translated into the language of the patient and primary care provider.

In this approach, the psychiatrist also needs to be familiar with common general medical conditions, nonpsychotropic medications commonly prescribed by family physicians, and the potential effects each of these can have on the presentation and treatment of psychiatric disorders. He or she also needs to have some familiarity with other mental health and community resources and be able to develop integrated biopsychosocial formulations for people being seen. The psychiatrist must be able to adapt his or her skills to a very different context, work in unfamiliar environments, and be willing to learn from primary care colleagues.

Conclusion

Integrating psychiatrists within primary care settings can improve communication between psychiatrists and family physicians and enhance the continuity of care provided. It appears to be an efficient way of providing mental health care for large numbers of individuals with serious mental illnesses, many of whom may not otherwise have received any treatment. It provides additional support for family physicians handling these cases and offers innovative opportunities for family physicians to increase their skills and comfort. The components of the model are transposable to almost any community, where they can easily be adapted to local needs and resources.

Clinical Implications

- A sharing care program makes psychiatric care more accessible.
- The program offers opportunities for new approaches to continuing education.
- Additional support is provided for the family physician.

Limitations

- Patient outcomes were not measured.
- The role of the psychiatrist is likely to differ when a counsellor is not part of the attachment.
- Assumptions concerning patient satisfaction were inferred.

Acknowledgement

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References


Résumé

Objectif : Une des façons de consolider les liens entre les dispensateurs de soins primaires et les psychiatres est de demander à un psychiatre de visiter un cabinet de soins primaires sur une base régulière, pour y voir des patients, discuter des cas avec les médecins de famille et leur fournir des renseignements et des conseils. Le présent article traite de l’expérience réalisée à Hamilton (Ontario), où des psychiatres et des conseillers ont visité 88 médecins de famille de la région répartis entre 36 cabinets.

Méthode : Les données portent sur les activités menées par des psychiatres de 13 bureaux, sur une période de 2 ans. Les données ont été recueillies à partir des formulaires usuels remplis par les médecins de famille qui demandent une consultation en psychiatrie, ainsi que par les psychiatres pour chaque nouveau cas. Des données ont également été obtenues du questionnaire de satisfaction remis chaque année à l’ensemble des dispensateurs de soins participant au programme.

Résultats : Durant une période de 2 ans, 1 021 patients ont été vus par un psychiatre équivalent à temps plein. La durée moyenne de chaque consultation a été de 51 minutes et, dans 12 % des cas, un membre de la famille était présent. Vingt et un pour cent des patients ont été vus à nouveau au moins une fois et, dans 75 % de ces cas, il s’agissait d’une visite de suivi prévue. De plus, 1 515 cas ont été discutés durant ces visites, sans que le psychiatre ne voit le patient. Un taux élevé de satisfaction a été observé chez tous les participants au projet.

Conclusion : Au nombre des avantages d’une telle approche, mentionnons une plus grande accessibilité aux consultations psychiatriques, un meilleur suivi des soins, le soutien offert aux médecins de famille et l’amélioration des communications entre les psychiatres et les médecins de famille. Ce modèle, qui offre de grandes possibilités novatrices en ce qui a trait aux programmes d’éducation permanente et au placement des résidents, exige toutefois de nouvelles aptitudes des psychiatres qui y participent.