Shared Mental Health Care in Canada

Current status, commentary and recommendations

A Report of The Collaborative Working Group on Shared Mental Health Care

December 2000

College of Family Physicians of Canada  Canadian Psychiatric Association

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ISBN 0-9699992-5-9
Executive Summary

In 1996, the College of Family Physicians of Canada (CFPC) and the Canadian Psychiatric Association (CPA) identified a need for increased collaboration between family physicians and psychiatrists. In order to address this issue, the CFPC and the CPA struck a task force whose mandate was to examine problems in the relationship between psychiatry and family medicine, and identify ways in which the relationship could be improved. In 1997, the task force produced a position paper which identified shared mental health care as a solution which would support both family physicians and psychiatrists, and would be likely to lead to better outcomes for patients. This position paper, *Shared Mental Health Care in Canada* was endorsed by the boards of the CFPC and the CPA and was jointly published in October 1997.

Shared mental health care is based on the following principles:

- Family physicians and psychiatrists are part of a single mental health care delivery system.
- The family physician has an enduring relationship with a patient that the psychiatrist should aim to support and strengthen.
- No single provider can be expected to have the time and skills to provide all the necessary care a patient may require.
- Professional relationships must be based upon mutual respect and trust.
- Roles and activities of family physicians and psychiatrists should be defined, coordinated, complementary and responsive to the changing needs of patients, their families and other caregivers, as well as to resource availability.
- The patient must be an active participant in this process, understanding that both the family physician and psychiatrist will remain involved in his or her care, and knowing who to contact when a particular problem arises.
- Shared care should be sensitive to the community context in which such care takes place.

To further this work and to facilitate the implementation of recommendations made in the joint position paper, the CFPC and the CPA established the Collaborative Working Group on Shared Mental Health Care in 1998. The ultimate purpose of the Working Group was to enhance the quality of care for Canadians with mental health problems through better collaboration between family physicians and psychiatrists.

The Working Group started its work by reviewing the current status of collaboration between family physicians and psychiatrists across Canada. An extensive survey of clinicians, educators, researchers, heads of academic departments, and health system planners and policy makers identified more than 350 individuals interested or involved in shared mental health care. The list now forms the basis of a national network of colleagues who are able to share their experiences with shared mental health care strategies, and who will constitute an important resource for others who wish to explore collaborative care.

A second survey of residency program directors in both family medicine and psychiatry provided the Working Group with important information about the status of shared mental health care as a curriculum component, about obstacles to the teaching of shared mental health care principles and practices, and about resources which are needed to support shared mental health care as a curriculum component. Work on these resources and on training objectives has already begun.

A review of continuing medical education programs across Canada (CME) was conducted to determine how well these programs meet the needs of family physicians for up to date psychiatric knowledge and whether they provide family physicians with the skills necessary to work collaboratively with psychiatrists. A number of deficits were
identified. These will be shared with CME planners, and the Working Group will develop resources to help CME program planners incorporate topics relevant to shared mental health care.

The Working Group reviewed provincial fee structures for family physicians. Non-supportive features of each of these often weighed on the side of discouraging family physicians from providing effective mental health care. Appropriately structured remuneration systems must be in place if shared mental health care is to be implemented successfully. Psychiatrist remuneration issues will be reviewed in the next phase of the Working Group’s mandate.

As health care reform is likely to have a significant impact on how family physicians and psychiatrists practice and on opportunities for collaboration, the Working Group conducted a review of selected federal and provincial planning documents related to primary care reform and mental health care reform. The findings of this review will be circulated widely to planners and policy makers. The Working Group will actively pursue opportunities to encourage and support greater integration in planning, and greater support for collaborative care in policy development.

Finally, the Working Group searched the literature and has created a bibliography of 165 references which deal with the interface between psychiatry and family medicine. These references are appended to the report and will form the basis for the annotated bibliography. It is intended that the annotated bibliography will support the development of a national research agenda.

Building on this foundation, the Working Group is now in a position to propose an agenda for completion of its mandate. This will involve:

- Development of more extensive processes to disseminate the findings of the group’s reviews and analyses.
- Expansion of the network of individuals interested/involved in shared mental health care and creation of a detailed registry of projects and activities across Canada.
- Development of local and provincial infrastructures to enhance and extend the work of the Working Group.
- Development of resources and ‘tool kits’ for residency program directors and CME program planners.
- Development of an annotated bibliography and critical overview of the literature on shared mental health care.
- Development of a process to create a national research agenda.
- Strengthening of liaisons with Ministries and other funding sources to advocate for policy and funding changes which will support shared mental health care.
- Development of a process to work with those who are responsible for providing mental health care to rural and other underserved populations, to identify ways in which shared mental health care could help to meet their needs.
- Strengthening of links with other professional provider groups who have an interest in collaborative mental health care.

The Working Group has set an ambitious agenda, but with the continued support of the boards and staff of the CFPC and the CPA, it looks forward to the achievement of these goals.
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Background

In 1996, the Canadian Psychiatric Association (CPA) and the College of Family Physicians of Canada (CFPC) identified a need for increased collaboration between family physicians and psychiatrists.

The prevalence of mental health problems in primary care settings is high. Approximately one third of all family practice patients have identifiable mental health problems and up to 25% of patients who visit their family physician have a diagnosable mental disorder. The family physician is in an ideal position to identify and treat mental health problems at an early stage: up to 97% of Canadians have a family physician and more than 80% visit their family physician in the course of the year. Moreover, the family physician is usually the first, and may be the only contact with a health care provider for individuals with mental health problems.8

It is not surprising, therefore, that family physicians report spending a large proportion of their time diagnosing and treating individuals who have emotional or psychiatric problems. Unfortunately, many feel unsupported in this role. Studies of family physicians in Canada and in other countries have consistently reported problems in family physicians’ relationship with psychiatrists, including problems in communication, difficulty in accessing consultation and treatment services, and a lack of respect and support.

Psychiatrists echo some of these complaints and report additional ones: poor communication and inadequate information from family physicians at the time of referral, reluctance on the part of family physicians to take responsibility for the continuing mental health care of patients once an acute episode has been stabilized, and frustration with family physicians’ lack of understanding of mental health legislation.

Compounding these problems are resource issues and health care policy changes which place additional pressures on the psychiatry/family medicine interface. Shortages of psychiatrists in many areas, particularly rural areas, increasing emphasis on community-based care, and decreasing lengths of stay in hospital mean that family physicians and community psychiatrists are frequently being asked to care for more acutely ill patients. In the face of these pressures, continuity of care, comprehensive, integrated care, collaborative care planning and the holistic approach to the individual are values which are increasingly difficult to maintain.

In order to address these issues, the CFPC and CPA struck a task force whose mandate was to examine problems in the relationship between family physicians and psychiatrists. The 1997 CFPC-CPA joint position paper: "Shared mental health care in Canada."
psychiatry and family medicine and identify ways in which the relationship could be improved. In 1997 the task force produced a position paper which identified shared mental health care as a solution which would support both family physicians and psychiatrists, and would be likely to lead to better outcomes for patients. This position paper *Shared Mental Health Care in Canada* was endorsed by the boards of the CPA and the CFPC and was jointly published in October 1997.

Shared mental health care is based on the following principles:

- **Family physicians and psychiatrists are part of a single mental health care team.** The family physician has an enduring relationship with a patient that the psychiatrist should aim to support and strengthen.
- **No single provider can be expected to have the time and skills to provide all the necessary care a patient may require.**
- **Professional relationships must be based upon mutual respect and trust.**
- **Roles and activities of family physicians and psychiatrists should be defined, coordinated, complementary and responsive to the changing needs of patients, their families and other caregivers, as well as to resource availability.**
- **The patient must be an active participant in this process, understanding that both the family physician and psychiatrist will remain involved in his or her care, and knowing who to contact when a particular problem arises.**
- **Shared care should be sensitive to the community context in which such care takes place.**

Shared care covers a broad spectrum of collaborative treatment possibilities. No single model or approach will be applicable in every community or clinical context. At the very least, it involves clear, helpful, two-way communication between the family physician and psychiatrist or psychiatric service. At the other end of the spectrum, it may involve psychiatrists and/or other mental health workers providing consultation and treatment in the family physician’s office, and developing collaborative management plans with family physicians. Shared mental health care should lead to improved patient outcomes and quality of life; a more efficient use of resources; optimal use of the time and skills of family physicians, psychiatrists and other providers; improvement in the ability of family physicians to access timely and appropriate psychiatric consultation and backup; and enhanced morale on the part of the providers.

The CPA/CFPC position paper outlined system-wide changes required to support the implementation of shared mental health care and suggested recommendations for changes in residency training programs, relationships between academic departments of family medicine and psychiatry, and continuing medical education programs. It also outlined potential barriers to implementation and identified special issues relevant to shared mental health care in underserved populations.

### The Collaborative Working Group on Shared Mental Health Care

To further this work and to facilitate the implementation of recommendations made in the joint position paper, the CPA and CFPC established the Collaborative Working Group on Shared Mental Health Care in 1998. The Working Group consisted of 5 members from each organization with a co-chair from each. Each of the major regions of Canada was represented.

**The ultimate purpose of the Working Group was to enhance the quality of care for Canadians with mental health problems through better collaboration between family physicians and psychiatrists.**

The specific objectives of the Working Group were:

- To facilitate implementation of recommendations made in the joint position paper.
- To introduce a national agenda for collaboration in order to facilitate the implementation and evaluation of this agenda, and to identify areas where increased collaboration is needed.
- To further our knowledge and understanding of the impact and benefits of shared mental health care.
- To strengthen personal contacts and improve communication between family physicians and psychiatrists.
- To improve the skills of family physicians and psychiatrists in working collaboratively in order to enhance the mental health care received by their patients.

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To advocate for changes within health care systems that will lead to greater collaboration between family physicians and psychiatrists and to improved mental health care for patients.

To serve as a resource on issues related to mental health care delivery to the boards of the Canadian Psychiatric Association and the College of Family Physicians of Canada.

In order to meet these objectives, the Working Group defined a series of questions which helped direct its work.

- How do health care policy and planning influence shared mental health care?
- What are the current activities in shared mental health care in Canada? Who is involved? What projects and initiatives are already underway?
- Are we training our residents in shared mental health care?
- Do current continuing medical education opportunities for family physicians support shared mental health care?
- Are there barriers and/or incentives to shared mental health care? How does physician remuneration influence mental health care delivery?
- How could the needs of underserved populations be addressed by shared mental health care?
- What research has been published on shared mental health care and its effectiveness? What should the research priorities be?
- How can we share this information? And with whom?
- How can we advocate for shared mental health care?

This report describes the activities of the Working Group during its 3-year mandate, summarizes the information it has gathered, and provides initial analysis of its implications. Based on this, the Working Group proposes recommendations it believes will help lead to more effective mental health care by supporting the concept of shared mental health care. Detailed background documents on specific activities of the Working Group may be obtained from the CFPC or CPA (see page 23).
Health care policy and planning

As health care reform is likely to have a significant impact on how family physicians and psychiatrists practice and on opportunities for collaboration, the Working Group conducted a review of selected federal and provincial planning documents related to primary care reform and mental health care reform. Both the CFPC and CPA submitted documents from their files, and provincial and federal ministries were approached to provide what they believed to be their key planning documents. The goals of the review were to improve our understanding of the policy and planning context and to identify policies or initiatives that might have an impact on shared mental health care.

A number of recurring themes emerged from the planning documents. Policy makers and planners in every province in both mental health reform and primary care reform identified and expressed similar goals. They proposed health services goals (see Table 1).

These goals are consistent with the goals of shared mental health care. Moreover, shared mental health care has the potential to facilitate their achievement.

Mental health care reform

Many of the mental health planning documents acknowledge the role of the family physician as a provider of mental health care. The Manitoba document\(^ 15\) states: “General practitioners already play a key role in mental health services in Manitoba. Recently, of the 110,000 individuals who received mental health services in the province, more than 80,000 were seen by general practitioners (20,000 were seen by psychiatrists and 9,000 by community mental health workers - usually RPN or Social Workers).” The British Columbia document\(^ 16\) states: “For many people with mental illness, the general practitioner is the primary provider of treatment.” In Nova Scotia: “General practitioners... already play a significant role in providing crisis services.”\(^ 17\) And in a letter accompanying the Saskatchewan mental health reform document\(^ 18\): “In Saskatchewan, the general practitioners see about 100,000 people each year for mental health reasons and collaborate to a considerable degree with psychiatrists around the province.”

Several mental health reform documents also identified a need for more collaboration between family medicine and psychiatry. The federal

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“Best Practices” document\(^ 19\) states “New service delivery models are needed that can link family physicians with mental health professionals.” The Ontario document\(^ 20\) calls for “New service delivery models that link family physicians with mental health specialists...” In Nova Scotia, planners stated that “General practitioners... should be

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provided with education to enable them to play a larger role in mental health emergency crisis services.” The British Columbia document states that “Because recruiting sufficient numbers of psychiatrists to rural communities is a challenge, providing adequate training and support to general practitioners is key to ensuring that effective diagnosis and treatment of mental illness is made available in all communities.” And finally, the North West Territories document emphasizes that “strong links between family physicians ... and mental health specialists or psychiatrists are vital to ensure that (people diagnosed with mental illness) receive consistent and timely treatment.”

Primary care reform

While the prevalence of mental health problems in primary care is high and managing these problems occupies significant amounts of the family physician’s time, to date, primary care reform documents have placed little emphasis on supports for mental health care in primary care.

The 1996 Report of the Advisory Committee on Health Services suggested principles on which primary care reform could be based. Amongst its specific recommendations were that “in urban and some rural areas, primary care organizations will have available a spectrum of professionals including physicians, nurses, psychologists, midwives, physical therapists, dieticians, counsellors and social workers.”

Since then, as most provinces have embarked on primary care reform, a number of provincial planning documents, such as the Nova Scotia document, have focused on local pilot projects which did not include a major mental health component. Others have suggested one of two general approaches to supporting provision of mental health care in primary care. The first has been to integrate a broader range of services into primary care settings and the second is to link primary care services more closely with other health and social services. Both of these approaches are consistent with the goals of shared mental health care.

Ontario’s report makes perhaps the clearest statement in this regard, seeing mental health care as a “mandatory function” of primary care while also stressing the value of “special attachments with mental health workers”. Saskatchewan sees the value of “community therapist and social workers” in “larger primary care sites” and discusses possible roles for these individuals such as “supporting families” and “addressing health risks for young people”. The Saskatchewan document also talks about integration of primary care services with a variety of other health services such as “public health, mental health and drug services within the host district”.

Problems

While it is encouraging to find the need for greater collaboration between family medicine and psychiatry emphasized in some of these documents, a number of problems remain.

Despite their similar goals, the primary care and mental health care planning processes appear to be occurring in parallel with little integration or cross consultation. There were no indications in documents reviewed to suggest that there were any formal linkages between the two processes. This raises serious issues regarding coordination and efficient use of resources and encourages separation of the constituencies which serve the chronic, persistent and severely mentally ill and those where episodic disorders, phase of life problems, and complex psychosocial difficulties are the primary focus of care.

Although a number of mental health planning documents acknowledge the role of the family physician as an important provider of mental health care, few actually incorporate the role of the family physician into the design of the mental health care delivery system. The primary care component of mental health is not described or defined, is not identified as part of the continuum of mental health care, rarely appears on organizational charts and system diagrams, and is usually conceptualised as beginning with entry into the formal mental health care system. Few documents address the physical health care needs of individuals with mental health problems and the need for integration of physical and mental care.

The role of the family physician in providing mental health promotion, screening, early detection and treatment and appropriate referral to specialized

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services is not discussed in these documents. Similarly, a number of documents discuss the issue of discharge from specialized, often regionally based services, back into the community but fail to outline the role of the family physician in providing follow-up care. These activities are critical to the successful care of individuals and to the successful functioning of the mental health care system.

The fact that mental health services do not figure prominently in reform planning is concerning, in light of the high prevalence of mental health problems in primary care and the amount of time family physicians spend managing them.

At the same time, our review of planning documents has revealed a high level of consistency between the goals of primary care and mental health care reform and the goals of shared mental health care. Shared mental health care could be seen, therefore, not only as a key component of both of these processes but also as a bridge to help link them.

### Recommendations

- Provide feedback of the results of the Working Group’s policy review to health policy makers and planners.
- Continue exchanges with health policy makers and planners to facilitate the implementation of shared mental health care by
  - monitoring and reporting on health policy/planning initiatives as they impact on shared care
  - identifying and communicating with key committees that may have an influence on the interface between mental health planning and primary care reform and developing recommendations to facilitate the integration of these two processes
  - extending this review to other policy areas and analysing their implications for shared mental health care (e.g. hospital restructuring, the continued shift to community care, rural health strategies, etc.).
- Identify, review, and report on areas where governments are investing resources for demonstration projects, research and evaluation of shared mental health care.
- Develop collaborative linkages with advocacy groups such as the newly formed Canadian Alliance on Mental Illness and Mental Health (CAMIMH).
The current status of shared mental health care in Canada

An important task for the Working Group was to develop a comprehensive list of individuals with an interest in shared mental health care across Canada. A “fanout” technique was used, beginning with the members of the Working Group and their colleagues. Heads of provincial medical and psychiatric associations and CFPC chapters were approached and asked to provide the names of individuals who are either currently active in, or who had expressed an interest in, shared mental health care. Similarly, heads of academic departments of family medicine and psychiatry were also contacted.

The people identified were surveyed to gather information about collaborative projects taking place across Canada. These “key informants” were sent a questionnaire asking them about collaborative shared mental health care activities, projects or activities in their areas, local government initiatives relevant to shared mental health care, and what they considered to be barriers or obstacles to shared mental health care in their community.

To date, the Working Group has collected the names of more than 350 individuals who are interested and/or involved in shared mental health care across Canada. Those who responded to the survey described and identified a broad range of shared mental health care projects and activities. The following are examples:

**Service projects**

- telemedicine consultation and backup to family physicians
- outreach to underserved populations, particularly in rural areas
- family physicians providing mental health services in psychiatric settings, including specialized clinics, inpatient wards and general outpatient clinics
- community psychiatrists providing consultations in the primary care setting for a wide range of problems, including specialized consultation for paediatric and geriatric age groups
- mental health services provided by psychiatrists and other mental health workers integrated within the primary care setting

- psychiatrists providing telephone backup to family physicians

**Educational resources for family physicians**

- treatment guidelines produced specifically for primary care physicians, such as the WHO Diagnosis and Management of Common Disorders in Primary Care, the Prime MD, and the Clarke Institute for Psychiatry’s Guidelines for Depression
- McMaster University’s Depression Information Resource and Education Centre (DIRECT)

**Continuing medical education activities**

- Balint-type groups
- single and multi-session courses for family physicians
- Practice-Based Small Group Learning modules
- single issue initiatives such as the “Access Program” to train family physicians across Canada about schizophrenia

**Residency training program initiatives**

- family medicine third year training opportunities in psychiatry
- adult and child psychiatry training opportunities in the primary care setting
- behavioural science training which is integrated into family residency training programs

**Collaborative activities between academic departments**

- reported less frequently, but included cross appointments, joint administrative projects,
regular meetings of department heads, and cross representation on department committees

Research activities

- collaborative research involving family physicians and psychiatrists
- research sponsored by psychiatrists about family physicians’ needs
- evaluation of shared mental health care strategies and their effectiveness

The number and scope of these activities and projects is exciting and encouraging. A significant problem, however, is that many are occurring in isolation without much dialogue with colleagues in other parts of Canada who may share these interests.

Recommendations

- Develop a web site, Listserve, and other approaches to disseminate this information and encourage networking.
- Maintain and expand the current network of clinicians, teachers, planners and researchers using the Internet, local and national meetings, and other formats for disseminating information.
- Develop a standardised descriptive inventory of shared mental health care projects or activities taking place across Canada, to publicise what is currently taking place nationally and serve as a resource for others wishing to implement shared mental health care strategies.
The joint position paper stated that many problems in the relationship between family physicians and psychiatrists reflect the fact that little attention is paid to collaborative models of practice in residency training programs.

The Working Group conducted a survey of the program directors of all Canadian family medicine and psychiatry residency programs to determine the current training experience of residents in shared mental health care. The specific objectives were:

- To assess the awareness of shared mental health care in family medicine and psychiatry residency programs.
- To determine the extent to which the joint position paper was influencing training.
- To identify the types of interactions between the two groups of residents.
- To identify obstacles to the implementation of shared mental health care principles and practices.
- To list and rank resources which would be helpful to family medicine and psychiatry residency programs in implementing shared mental health care.
- To determine to what extent psychiatry residency programs are responsible for the teaching of psychiatry/behavioural medicine to family medicine residents and vice versa.

The questionnaires sent to the family medicine and psychiatry programs were similar enough to permit direct comparison of the results. 14 out of 16 of the psychiatry surveys and 15 out of 16 of the family medicine surveys were returned. Some family medicine program directors commented that it was difficult to make general statements about their programs because of the variation among their teaching sites.

The principal results of the surveys were:

- Most program directors in both departments were aware of the joint position paper. In many family medicine programs it had been used to develop goals and objectives.
- The majority rated shared mental health care as being important in training.
- The document had not been discussed as much in postgraduate education committees in psychiatry as in family medicine.
- The majority of family medicine teaching units have a visiting psychiatrist to assess/discuss cases. Some commented that this does not happen frequently enough. Some psychiatry residents participate in this at some point in their training. There is considerable variation in the type of experiences available.
- There appears to be limited contact between family physicians and psychiatrists in their respective practice settings.
- Few programs offered joint educational sessions for family medicine and psychiatry residents.
- Neither department identified major obstacles to teaching the principles and practice of shared mental health care.
- Programs indicated that improved relationships between departments would facilitate the teaching of shared mental health care.
- Program directors in both disciplines identified the need for influential role models and leaders in theory and practice of shared mental health care.
- Program directors in both disciplines identified the need for teaching materials, training objectives and additional human resources to teach shared mental health care in their programs.

Separate meetings have been held with family medicine and psychiatry program directors to discuss these findings, and program directors have received copies of the findings and recommendations of both surveys. The Working Group has developed draft training objectives in psychiatry for family medicine residents and in family medicine for psychiatry residents. These have been circulated to program directors for their feedback.
**Recommendations**

- Continue to collaborate with program directors to finalise the learning objectives and to assist in their implementation.

- Further explore ways in which university departments of family medicine and psychiatry could increase contacts among faculty members and learners from each department and facilitate the collaborative development of educational (and other) programs.

- Develop strategies to assist residency program directors in meeting the needs identified in the surveys e.g.
  - provide suggestions for topics for tutorials and seminars
  - provide a current list of references on shared mental health care and descriptions of existing collaborative programs
  - identify potential opportunities for activities that bring psychiatry and family medicine residents together, such as educational rounds, tutorials and joint clinical placements.

- Promote and encourage the participation of residents in shared care projects/programs throughout their training.

- Create a registry (from the national database) of educators with an interest in shared mental health care.

- Continue liaison with the CFPC and the Royal College of Physicians and Surgeons of Canada to incorporate concepts of shared mental health care in family medicine and psychiatry residency training requirements, respectively.
Continuing medical education

Family physicians are more likely to be comfortable participating in the mental health care of patients with psychiatric disorders if they have adequate knowledge about these disorders, and the skills to work collaboratively with psychiatrists. Consequently, the Working Group identified continuing medical education (CME) as an important factor in the successful implementation of shared mental health care. A review of recent CME programs across Canada was conducted to determine how well these programs meet the needs of family physicians for up to date psychiatric knowledge and whether they provide family physicians with the skills necessary to work collaboratively with psychiatrists and other mental health professionals.

Three sources of CME programs for family physicians were reviewed – the annual scientific assemblies of the CFPC, the programs offered by the university CME offices, and other programs accredited by the CFPC. Unaccredited CME and specially CME were not renewed, nor was a literature search undertaken.

**CFPC annual scientific assemblies:** All CFPC chapters and the national office were asked to submit their ASA programs for the years 1994-1998. All but one of the chapters were able to provide all of the programs. These were reviewed in detail, and each topic was classified under a broader subject category heading (e.g., cardiology, endocrinology, office management, ethics and legal issues). Topics were classified under psychiatry and mental health if they dealt with a DSM-IV diagnosis, psychopharmacology, psychotherapy, or fell under the broader heading of psychosocial problems (e.g., parenting techniques, coping with an alcoholic family member, phase of life issues, etc.).

Thirteen percent of all presentations were on topics relevant to mental health care. This compares favourably to other areas, such as respirology (3%) and infectious diseases (5%). The frequency of mental health topics varied widely, however, from province to province. Ontario had 42 mental health CME topics over 5 years, and the combined Maritime Provinces had 11. The mean for all provinces was 21.

Of the mental health care topics, depression was the most common topic (14%), followed by counselling/psychotherapy (11%), alcohol abuse (11%) and family violence (10%). Other topics were anxiety disorders (5%), personality disorders (3%), bipolar affective disorder (1%), and schizophrenia (1%). There was one presentation on suicide risk assessment in five years across Canada.

None of the topics specifically addressed shared mental health care or the skills and knowledge necessary for co-management of the seriously mentally ill.

**University CME offices’ programs:** All sixteen Canadian medical schools have offices that provide CME for family physicians. They were asked to provide statistics on the activities they planned during a 12-month period (October 1998 to September 1999). Ten universities responded. Across these universities, there were a total of 553 activities. Of these, 43 (7.8%) were on mental health topics, and a further 95 (17.2%) were general programs which included at least some mental health content.

**CFPC database of accredited CME:** The central CFPC database for other accredited CME events was reviewed for a 12-month period from 1998-1999. The data for the CFPC ASA’s was excluded. Mental health care topics, as defined above, were extracted and analysed. Review of this data produced results similar to the ASA’s: 12% of all topics were categorized as mental health.

The overall frequency of psychiatry/mental health topics in family medicine CME (8-17%) activities is encouraging. But the low frequency of presentations on some common and serious psychiatric problems (such as anxiety disorders, bipolar affective disorder, and schizophrenia) is concerning. Similarly, the absence of any topics in family medicine CME dealing with the skills necessary to co-manage patients with mental health disorders is a potential barrier to the dissemination of the shared mental health care model.
**Recommendations**

- Disseminate the findings of these reviews, which highlight the relative lack of certain important topics to CME providers. CME opportunities for family physicians and psychiatrists reflect local practice contexts and community needs and place increased focus on the diagnostic, management and inter-professional skills needed for collaborative care. Disseminate these results to psychiatrists involved in delivering CME to family physicians.

- Prepare a list of core topics and background materials relevant to shared mental health care in conjunction with organisers of CME events and national groups such as the Council of Psychiatry Continuing Education (COPCE).
Opportunities and barriers

Opportunities and barriers were identified in a number of ways including: the survey of key informants, the surveys of residency program directors, and a review of provincial fee schedules for family physicians. The Working Group was also invited to contribute questions on the relationships between psychiatrists and family physicians to the 1999 survey of the Canadian Psychiatric Association Research Network (CPARN). This survey was sent to 160 (self-selected) psychiatrists across Canada. The following issues arose from one or more of these sources.

Health care system restructuring was mentioned by some of the respondents of the key informant survey as offering many opportunities for collaborative projects, as many of the goals were consistent with those of shared mental health care. Specific factors mentioned included:

- the increasing emphasis on primary care as the cornerstone of health delivery systems
- hospital restructuring, which stressed the need for closer links between hospitals and community services
- primary care reform, which aims to integrate specialised services within primary care
- planning for enhanced rural services taking place in many provinces

There was broad agreement on the following major barriers to shared mental health care:

- time constraints
- limited personal contacts and poor communication between family physicians and psychiatrists
- physician remuneration for collaborative activities
- lack of funding for collaborative projects
- attitudinal barriers

Time Constraints

Many respondents identified this as an issue. Psychiatrists and family physicians both felt that it would be difficult to take time from their clinical activities to devote to activities for which there is no remuneration. This was not identified as a major problem for those physicians already involved in shared mental health care projects. The CPARN survey, however, suggested that psychiatrists would be willing to devote some additional time to joint clinical or educational activities or providing telephone backup.

Limited personal contacts / communications

A consistent theme was the need for improved communication and increased personal contacts between psychiatrists and family physicians. This applied to contacts between family medicine and psychiatry educators and educational program planners, between academic departments, between health planners responsible for mental health and primary care reform, and between clinicians working in different settings. Improved communication and closer personal contacts were seen as essential for effective collaboration and the implementation of shared mental health care.

According to the CPARN survey, the main contact between psychiatrists and family physicians took place over the phone (usually discussing cases). Psychiatrists felt that this was likely to be the most effective way of linking psychiatrists and family physicians. They also saw increased participation in joint rounds or education activities to be both desirable and achievable.

Physician remuneration issues

The Working Group reviewed the billing codes available to family physicians across Canada in order to determine how payment options either support or discourage effective mental health care. Notwithstanding the fact that some provinces provide a salary to family physicians in some settings (e.g. CLSC’s in Quebec and CHC’s in Ontario), and though the details vary considerably, the billing systems of all provinces are based on a similar fee-for-service model. In general, there are two kinds of codes: fees for office visits (usually for medical problems) which are defined according to the type of service performed; and fees for counselling or psychotherapy which are defined according to the amount of time spent with the patient.
Analysis of the various provincial fee systems revealed that they all have both strengths and weakness in terms of how well they support the provision of mental health care.

Examples of billing codes, which support the provision of mental health care by family physicians, include:

- health promotion counselling
- phone calls
- group counselling
- interviews with relative
- interviews with other health care professional
- complete “physicals” for mental illness
- case conferences
- psychotherapy and family therapy
- short time intervals for counselling/psychotherapy

But there were also features of the fee schedules that are likely to discourage the provision of mental health care by family physicians. Whereas most mental health care is billed using time-based codes, almost all uncomplicated non-psychiatric problems are billed using codes that are not time-based. The following specific barriers exist in at least one province:

- low rates for mental health care compared to general medical assessments and care
- no psychiatric care codes
- restricted number of annual visits billable for counselling
- requirement to pre-book visits for counselling or psychotherapy
- complex fee code systems
- fixed fee for psychotherapy regardless of time spent
- although some provinces have special codes for serious or catastrophic situations (e.g. rape, acute psychosis), none have any for common but disabling mental illness

The particular combination of these supportive and non-supportive features of the fee structures in each province often weigh on the side of discouraging family physicians to provide effective mental health care. Appropriately structured systems of remuneration must be in place if shared mental health care is to be implemented successfully. Codes that adequately remunerate both family physicians and psychiatrists for case discussions and telephone advice, in particular, are needed.

Limited funding for collaborative projects

Many respondents commented that even when the desire to implement shared mental health care strategies existed and the planning had been completed, it was often difficult to obtain new funding. This was often reinforced by local planning authorities that did not give a high priority to collaborative projects, or where funding was provided by different sources and was hard to integrate. While there is evidence that this is slowly changing, most projects had started by reallocating existing funding, or by pursuing non-traditional sources of funding such as the Health Canada Transition Fund.

Attitudinal barriers

Despite acceptance of the value of shared care by many psychiatrists and family physicians, attitudinal barriers still need to be overcome. These include stereotyped (and usually inaccurate) views of the work of the other discipline and a lack of respect for the role each could play. In part this stems from the lack of personal contacts between psychiatrists and family physicians and can be reinforced by a poor understanding of what takes place in the clinical settings of the other discipline and different conceptual frameworks regarding the aetiology of mental health problems.

There appeared to be agreement that the most effective way to change these attitudes would be to find clinical, educational and planning settings which would bring family physicians and psychiatrists into contact with each other, and enable them to learn about each other’s practice. It was suggested that this needs to start during residency training.
Recommendations

• Continue to develop strategies to enhance communication between family physicians and psychiatrists, including
  • further exploration of opportunities for hospital departments of family medicine and psychiatry to increase contacts among their members (including residents) by joint clinical rounds and educational activities, and the development of collaborative programs and evaluation processes
  • compiling and circulating examples of clinical forms and communication processes that significantly improve the exchange of clinical information between the two specialties.

• Request provincial medical associations and health insurance plans to review fee schedules for mental health services by family physicians to ensure that they do not undermine the role of the family physician as a provider of mental health care. Fees for activities that would support collaborative activities such as case discussions, telephone advice and conjoint assessments, should be considered. Conduct a similar review for psychiatry.

• Work with Government and other funding sources to advocate for resources for the implementation and evaluation of collaborative projects.

• The Working Group act as a clearinghouse for the compilation and dissemination of evaluation materials and strategies in shared care, to enable individuals embarking on new projects to learn from the experiences of colleagues.

• Further assess psychiatrists’ attitudes towards shared care and the types of supports and resources they feel are necessary to facilitate implementation.
Underserved populations

Rural / isolated communities

Many of Canada’s rural or more isolated communities have shortages of medical specialists, including psychiatrists and other specialized mental health care providers. Attracting and retaining psychiatrists to these communities remains a priority, but because of the relative lack of success that many communities have had in this regard, alternate models for delivering mental health care have been developed.

Many of the models are based upon an acknowledgement of the central role that a family physician plays in delivering mental health services in these communities. Examples of these include outreach by psychiatrists who visit communities periodically to deliver clinical and educational services; telephone backup to family physicians; the use of new technologies for video consultations and case conferences and educational sessions; Web-based clinical and educational training activities; CME events; and specialized training for family physicians as mental health providers.

In addition to individual projects, there are examples of academic centres and provinces that have launched major initiatives to coordinate activities to outlying communities in their catchment area.

Shared mental health care offers many opportunities for innovative projects which could enhance the mental health care received by individuals in these communities.

Other underserved populations

Shared mental health care has been utilized to deliver mental health care to the homeless, immigrant and specific cultural groups, the elderly, individuals with co-existing medical and emotional problems, and native populations.

Recommendations

- Collaborate with organizations, health planners and providers working in more isolated or underserved communities to explore the role that shared mental health care can play in increasing access to mental health/psychiatric services. Steps towards achieving this will include
  - an overview of the types of unmet mental health needs in these communities
  - a review of existing projects that have successfully linked mental health and primary care services in isolated/underserved communities
- Liase with rural health organizations and ministry planners to assist in the development and evaluation of new/demonstration shared mental health care projects for collaborative activities in rural communities.
- Develop additional training opportunities in mental health care for rural-based family physicians in conjunction with academic departments.
- Document and describe successful strategies for providing service to other underserved populations and broad dissemination of these findings.
An annotated bibliography of shared mental health care

An important part of the Working Group’s strategy for supporting the implementation of shared mental health care is the development of an annotated bibliography and overview of the literature on shared mental health care. Together, these will comprise a reference document for individuals and groups interested in the experience with shared mental health care to date. In addition, they will support the development of a national research agenda and, hopefully, stimulate innovative new programs and activities.

The first step in this process, a Medline review of the English language literature for the years 1980-1998, has been completed. References were included if they dealt primarily with the interface between family medicine and psychiatry. One hundred and sixty-five references were selected (Appendix). These are also available, including their abstracts, in a separate document.

Interest in the relationship between family medicine and psychiatry, as demonstrated by the number of articles dealing with it, has grown rapidly in the 18 years covered by the search. Between 1980 and 1984, 12 articles dealing with the interface between family medicine and psychiatry were published. For the five-year period from 1994 and 1998, 80 references were found.

The majority of articles included are British in origin. However, work by groups in Australia, the U.S. and Canada is now being published with increasing frequency.

The references generated by this search include descriptive studies, intervention studies, discussion papers, editorials, letters, and position papers published by professional bodies, all dealing with the relationship between family medicine and psychiatry. The content of these references includes, among others, the following topics:

- family physicians’ attitudes toward increased collaboration with psychiatrists
- the prevalence of formal links and collaborative arrangements between family physicians and psychiatrists and other mental health professionals
- models of collaboration, their advantages and disadvantages
- descriptions of specific collaborative programs and services in Canada, the United Kingdom, Australia, the U.S., the Netherlands, and Israel
- family physician and patient responses to these programs
- program costs
- impact of collaborative programs on the existing network of psychiatric services
- impact of collaborative programs on family physician knowledge, skill, and mental health care practices
- suitability of collaborative models for special populations and settings (e.g. children and adolescents, rural settings, substance abusers, the military)
- the seriously mentally ill, and the issues related to serving this population

Initially, much of the literature on shared mental health care was descriptive or conceptual in nature. In more recent years, well-designed outcome studies are beginning to demonstrate what works well, with what populations, and what does not. Of particular interest is the growing number of references which deal with shared mental health care in relation to the seriously mentally ill. Many of these articles, letters and editorials raise questions about resources and the need to ensure that they are not diverted from this population.

Research strategy

At present, there is not a substantial body of Canadian literature about shared mental health care and its implementation, despite the increasing number of individuals involved in collaborative practice. The results of the surveys of key informants and academic departments suggest that there is little funded research currently taking place in Canada that examines different facets of the relationship between psychiatry and primary care. Many of the investigative activities that are taking
place fall under the category of program evaluation or are funded through resources already allocated to specific programs.

The Working Group recognises the importance of facilitating both effective evaluation and well designed research projects. The demonstration of the benefits of collaborative care will be a crucial factor in negotiations for funding for further research, as well as providing support and guidance for practitioners working in the field.

Because of limitations in resource availability, the more that individuals in different parts of the country can collaborate and draw on their collective experiences, the more efficient research activities are likely to be. At the same time, if different groups are addressing common or complimentary questions, they have the opportunity to build upon each other’s work.

**Recommendations**

- Complete the annotated bibliography with a critical overview and with references organized under content headings. Circulate the resulting document widely to educators, learners, planners and service providers.

- Establish a representative national group of persons who research and evaluate activities in shared mental health care by
  - linking individuals across the country who are interested in research and evaluation
  - compiling, maintaining and distributing a list of current research, evaluative activities, and related publications.

- Develop a national research and evaluation strategy that includes, among others, the following issues
  - sponsoring a process to develop a national research agenda and a framework to ensure a coordinated approach to research and evaluation
  - the most effective use of resources including cost-benefit analyses of shared mental health care strategies
  - the optimal roles for family physicians and psychiatrists working together to deliver mental health care
  - which interventions/strategies are most likely to result in improved patient outcomes
  - how to use shared care strategies to improve the care provided for hard to serve populations
  - how to implement shared care strategies on a large scale
  - impact of shared mental health care on the health of the population.

- Advocate for increased funding for research and evaluation.
Advocating for shared mental health care

Information about shared mental health care and the collaboration between the CFPC and CPA was disseminated widely after the release of the joint position paper using a variety of communications vehicles. Communications and advocacy activities focused on reaching the following audiences: members and the governing bodies of the two sponsoring organizations, officials who influence and are responsible for policy, planning, and funding of the primary and mental health care systems, medical educators, and allied professional organizations.

The objectives were to inform audiences about the activities of the Working Group and to foster a climate that encouraged individuals and groups involved or interested in shared care to share ideas or successful strategies and to discuss their experience. At the policy level, the objective was to begin to engage decision makers in a dialogue around the policy and funding issues in order to optimise the contextual framework for shared mental health care.

The key messages were:

- that physicians involved in mental health care were taking steps to improve patient care at the primary care level
- that the initial focus of the Working Group would be on gathering information about out how shared mental health care is being implemented in different communities and on issues and barriers that need to be addressed

The public release of the joint position paper in 1997 at a press conference held in Toronto and joint publication in each of the two organizations’ major publications, was followed by written communication to a wide range of medical and allied professional and consumer organizations and to senior health officials at the federal and provincial levels. Many supportive and encouraging responses were received.

While the Working Group recognised it needed to limit its discussions to collaboration between psychiatrists and family physicians – as the group had no mandate to speak on behalf of any other health care providers – most non-physician organisations contacted saw this activity as a positive step. They initiated independent discussions to explore how they could address shared care issues in mental health care within other domains. Two examples are discussions between social work and psychiatry around working with the homeless mentally ill population, and initial discussions around shared care in child mental health. Over the next three years it is hoped that these discussions will lead to more formal linkages with other mental health care providers.

In addition, the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) has invited representation from the Working Group to participate in planning a nation-wide system for monitoring mental disorders and developing an action plan to support mental health promotion and the treatment of mental disorders.

Throughout the 3-year mandate of the Working Group, information about its mandate, activities and progress has been disseminated in a variety of ways including national and international meetings, published articles, and media presentations. Progress was communicated regularly to members and governing bodies of the CPFC and CPA through Board presentations and news articles in each of the two organizations publications.

In addition, the surveys of academic centres and the network building among those already involved or interested in shared mental health care served to improve understanding within the two spheres of practice about the Working Group’s activities.

Some press relations work was undertaken, with the medical media producing a number of stories on shared mental health care activities such publications as the Medical Post and the American Psychiatric Association News.

Efforts were also made to foster communications and information-sharing mechanisms at the provincial level, often facilitated by representatives on the Working Group within their province. One province (Alberta) held a number of meetings between parties at the provincial level and reported back to the committee with a series of recommendations and issues it felt should be addressed.

Governments have responded extremely positively to the communications about the shared mental health care initiative. A series of follow-up written exchanges resulted from the original
communications between the Working Group and the Deputy Minister of Health Canada as well as the Chair of the Federal/Provincial/Territorial Health Services Advisory Board. As a result, the Working Group met with the Federal Provincial Territorial Advisory Network on Mental Health in April 1999. During that meeting, background on the current situation, an initial analysis of the extent to which primary care and mental health reform planning documents support shared mental health care in Canada, and the work of the committee were presented and discussed.

Subsequently, a co-chair of the Working Group made a presentation to a broad range of officials within Health Canada, which resulted in a commitment for some limited financial support for information dissemination. Communications to the CPA from the government generally point to shared mental health care as an illustration of the work they find encouraging. This has set the stage for potentially positive ongoing dialogue around policy changes needed to address some of the systemic barriers to the practice of shared mental health care.

Recommendations

• Develop a process to facilitate regular, ongoing dialogue with CFPC and CPA members, other physicians and other health care providers, educators, health care policy makers and planners and other medical and allied health care organizations.
  
  • The objectives of this dialogue would be to
    • advance the understanding of shared mental health care and its potential benefits
    • facilitate the implementation of the recommendations of the position paper especially as they relate to human resources, system planning, funding, training, and research.
  
  • Strategies could include
    • continued development and expansion of a web-site containing information available to members and others with an interest in shared mental health care
    • regular publication of the work of the Working Group in appropriate journals and other media
    • wide and targeted distribution of this report, including a press conference around its release
    • regular presentations at professional and CME meetings
    • periodic meetings and ongoing dialogue with medical training, accrediting, and CME bodies to share the results of surveys and explore strategies to improve shared care training as well as to find solutions to identified barriers
    • continued ongoing information exchange meetings with national governmental bodies (Federal provincial territorial committees) and Health Canada officials.
  
• Explore linkages with allied groups (including other professions and CAMIMH) through either a multi stakeholder meeting or a series of one-to-one meetings with key organizations. The purpose of such meetings would be to foster broader collaboration and integrate the multi-disciplinary nature of mental health care.

• Develop a comprehensive list of policy issues and strategies (research, funding, human resources, etc.) which both sponsoring organizations can jointly bring to the attention of governments to foster collaboration between primary care and mental health care reform initiatives.

• Establish provincial and local ‘shadow’ committees to advocate for policy and funding changes at the provincial level and to share information at a local level.
Plans for the future

The initial task of the Working Group was to gather as much information as possible on the current state of shared mental health care across Canada, on obstacles that might interfere with collaboration between family physicians and psychiatrists, and opportunities that might facilitate collaborative activities. Future plans of the Working Group include:

• Development of more extensive processes to disseminate the findings of the group’s reviews and analyses.

• Expansion of the network of individuals interested/involved in shared mental health care and creation of a detailed registry of projects and activities across Canada.

• Development of local and provincial infrastructures to enhance and extend the work of the Working Group.

• Development of resources and ‘tool kits’ for residency program directors and CME program planners.

• Development of an annotated bibliography and critical overview of the literature on shared mental health care.

• Development of a process to create a national research agenda.

• Strengthening of liaisons with Ministries and other funding sources to advocate for policy and funding changes which will support shared mental health care.

• Development of a process to work with those who are responsible for providing mental health care to rural and other underserved populations, to identify ways in which shared mental health care could help to meet their needs.

• Strengthening of links with other professional provider groups who have an interest in collaborative mental health care.
These documents may be obtained from the College of Family Physicians of Canada or the Canadian Psychiatric Association.


2. Detailed results of the surveys of family medicine residency program directors and of the survey of psychiatry residency program directors.

3. List of Canadian continuing medical education on mental health care for family physicians.

4. Review and summary analysis of Canadian federal and provincial primary care and mental health care reform planning documents.

5. Provincial billing codes pertinent to mental health care for family physicians.

Appendix: Literature on shared mental health care


73. Kendrick T, Burns T. Mental health teams should concentrate on psychiatric patients with greatest needs [letter; comment]. BMJ 1996;313(7061):884-5.


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