SHARED MENTAL HEALTH CARE IN CANADA

A Compendium of Current Projects

Produced by the Canadian Psychiatric Association and the
College of Family Physicians of Canada
Collaborative Working Group on Shared Mental Health Care

Editors:
Nick Kates
Sari Ackerman

The Canadian Psychiatric Association
and the College of Family Physicians of Canada
gratefully acknowledge the support of Health Canada
and the assistance of the
Hamilton HSO Mental Health & Nutrition Program
in producing this Compendium.

Table of Contents

UNDERSERVICED AREAS

COLLABORATIVE PROJECTS TO MEET THE NEEDS OF SPECIFIC POPULATIONS

TRAINING: RESIDENTS AND MEDICAL STUDENTS

CONTINUING EDUCATION PROGRAMS

RESOURCES

INTRODUCTION

Over the last five years, the relationship between mental health and primary care services has shown welcome signs of improvement and a growing recognition of the potential benefits of more effective collaboration between these two sectors. This has led to a remarkable growth in the range and diversity of collaborative projects across the country, supported by a collaborative initiative to promote shared mental health care between the Canadian Psychiatric Association and the College of Family Physicians of Canada.

As a result, communities and provinces are now exploring how to incorporate shared care in their service planning, and looking for new ways of strengthening links between mental health and primary care services. This compilation offers examples of projects that have succeeded in bridging this gap.

Some have a strong clinical focus, including projects that integrate mental health services within primary care settings or attempt to reach traditionally underserved populations. Others offer creative educational programs for family physicians in practice and for learners, or have created administrative frameworks to support greater collaboration. The Compendium also includes examples of program evaluation, epidemiological studies, needs assessments and research projects aimed at evaluating current models, although to date there is little Canadian data on the benefits of shared care.

One of our goals in gathering descriptions of these projects in a single volume is to provide a record of the current state of shared mental health care in Canada. We hope that readers of the guide will find ideas that might assist them in projects they are developing. We also hope that it will help to establish contacts between colleagues in different parts of the country engaged in similar activities.

Above all, however, when viewed together, these projects present an impressive picture of how two specialties can work together to strengthen their relationship and improve the care they offer their patients.

If you are interested in finding out more about the work of the Committee, particularly of our efforts to build strong provincial networks of individuals interested in shared mental health care, please contact Nick Kates at (905) 521-6133 or nkates@mcmaster.ca or Marilyn Craven at cravenm@mcmaster.ca, or visit our website at www.shared-care.ca.

Organisational Collaboration

For clinical collaboration to thrive, it needs to be supported by organisational changes at a hospital, community or provincial level. These can include establishing new planning partnerships, policy changes and a willingness to fund and evaluate new projects. This section includes descriptions of projects where different departments or organisations have developed new partnerships.

Some of the projects described involve collaborative relationships established between academic departments or within communities. Others describe programs that have taken major responsibility for organising activities to strengthen links between primary care and mental health services, including an Ontario-wide project where psychiatrists mentor (by phone) groups of family physicians. A further example is the National Conference on Shared Care that brings together colleagues from across Canada to exchange ideas and learn from each other's experiences.

It is also heartening to see Provincial Governments now actively looking at ways in which models of shared care can be incorporated into both primary care and mental health reforms, with closer contacts being established between planners in these areas.

Collaborative Project of the Canadian Psychiatric Association and the College of Family Physicians of Canada on Shared Mental Health Care

Funding: The working group is supported by the Canadian Psychiatric Association and the College of Family Physicians of Canada.

Starting Date: 1996

Rationale: Mental health and primary care providers were becomingly increasingly aware of the need for better collaboration to improve communication and support the key role family physicians play in delivering mental health care. Changes to the health care system (restructuring, primary care reform, problems with accessibility of psychiatrists) also suggested that new partnerships needed to be developed which strengthened the role of the primary care physician.

Goals: To identify areas where collaboration between psychiatrists and family physicians could enhance patient care and improve outcomes;

To introduce a national agenda for collaboration between psychiatry and family medicine and facilitate its implementation and evaluation through the Canadian Psychiatric Association and the College of Family Physicians of Canada.

Description: The two organisations produced a joint position paper on shared mental health care in Canada in October 1997. The document was circulated with the journals of the CPA and CFPC and a working group was set up to implement its recommendations, with a three-year mandate.

The working group reviewed the current state of shared care by looking at projects taking place across the country, and surveying key informants, including Chairs of Academic Departments of Family Medicine and Psychiatry and their Residency Program Directors, leaders of provincial medical and psychiatric associations and family medicine chapters, and individuals with an identified interest in the area. The group also examined potential obstacles to collaboration such as provincial billing tariffs and time constraints and the content of continuing education meetings for family physicians.

Based on these findings and further surveys, the working group developed recommendations for training residents and medical students and for continuing education programs. It established contacts with provincial and federal health planners to raise the importance of shared care and was successful in obtaining funding from Health Canada for the production of a compendium of projects in Canada and an annotated bibliography of shared care publications.

The group also built a network of individuals across Canada with an interest in shared care, linking individuals via a mailing list, the internet and a website and collaborated with staff at St. Joseph's Health Centre in organising Canada's 1st National Conference on Shared Mental Health Care.

The work of the group was summarised in a report and the two organisations agreed to renew the mandate of the working group until May 2003. During this time, the group will continue to build on the work already underway, including expanding the network of colleagues and building provincial infrastructures.

It will also develop a rural strategy and a national research agenda, as well as continuing to advocate for shared care with health planners. In addition, it will establish links with non-physician groups and look at what frameworks need to be established to build on the momentum established by the project.

Lessons Learned:

There has been substantial and increasing interest in shared care and the work of the national working group. The major role of the working group has been to publicise different approaches to shared care, its benefits and its opportunities with clinicians, academics, teachers, learners, health funders and planners and to link colleagues across the country who share a similar interest. Its activities need to be supported by strong local/provincial infrastructures which are in a position to implement recommendations being made.

Contacts:

Dr. Nick Kates, 40 Forest Avenue, 2nd floor, Hamilton, ON L8N 1X1
Tel: (905) 521-6133 Fax: (905) 521-6107 e-mail: nkates@mcmaster.ca

Dr. Marilyn Craven, Community Psychiatry Services, St. Joseph's Healthcare, Charlton Site, Fontbonne Building, 3rd floor, Hamilton, ON L8N 4A6
Tel: (905) 521-1155 ext. 4069 Fax: (905) 521-6059
e-mail: cravenm@mcmaster.ca

References:

Kates N, Craven M et al. Shared Mental Health Care in Canada. Supplement to the Canadian Journal of Psychiatry and Canadian Family Physician; October 1997.

Report of the Conjoint National Working Group on Shared Mental Health Care in Canada - College of Family Physicians of Canada/Canadian Psychiatric Association; April 2001.

National Conference on Shared Mental Health Care

Sponsoring Organizations: St. Joseph's Health Centre, Toronto
Canadian Psychiatric Association/College of Family Physicians of Canada
McMaster University
University of Toronto

Funding: Eli Lilly Canada, Inc.
Health Canada
Ontario Ministry of Health

Rationale: To stimulate broad interest, exchange and knowledge amongst health care providers, planners, funders and program developers about the shared care model, and partnership between primary care and psychiatry as a means of enhancing access to mental health care.

Goals: To provide practical information about the development and operation of a shared care service;

To present data and evidence supporting the current and future advantages inherent in the shared care model;

To address issues of population health, secondary and tertiary prevention, primary care reform and consumer choice as they pertain to the shared care model;

To raise awareness of educational opportunities (undergraduate and post-graduate) related to shared care;

To raise the provincial and national profile of shared mental health care.

Description: Held on June 2, 2000, the Conference included a keynote address by Dr. Nick Kates on "The Evolution of Shared Mental Health Care", a panel discussion on "Shared Mental Health Care: Evolution or Devolution", and luncheon keynote address by the Hon. Elizabeth Witmer, Ontario Minister of Health, on "Emerging Trends in Mental Health Care". Workshop topics included:

(1) Developing a shared care program: local provincial, national
(2) Educational opportunities with shared care
(3) Frontline perspectives: urban, multicultural, homeless, elderly
(4) Frontline perspectives: Northern, Western, Quebec
(5) Frontline perspectives: child and adolescent, family medicine, social work

A 2nd National Conference was held on June 7th and 8th, 2001. The theme was "Practice, Standards and Ethics - Across Disciplines". Speakers and workshops covered topics including legal and ethical issues, an international perspective, telepsychiatry, and shared care involving underserviced areas and populations. The Conference also addressed practical issues of starting a shared care program.

Key Findings: Evaluation of the first Conference elicited the following recommendations for future conferences: more discussion about interdisciplinary involvement, research, evaluation and education themes, time for information networking, more case presentations, and more on starting programs.

Implications: Following the success of the first two Conferences, organizers have decided to move the event to different locations in Canada. The 3rd Annual Conference will be held in Edmonton; the following year, the Conference will take place in Halifax.

Contact: Ms. Vicky Nicholson, Manager, Community Mental Health,
St. Joseph's Health Centre, Community Mental Health Services
SSW 4th Floor, 30 The Queensway, Toronto, ON M6R 1B5
Tel: (416) 530-6000, ext. 3395 e-mail: nichov@stjoe.on.ca

An Academic Collaboration: Family Medicine and Psychiatry at McMaster University

Sponsoring Organizations: McMaster University Department of Family Medicine
McMaster University Department of Psychiatry

Starting Date: 1997

Goal: To develop a formal collaboration between McMaster University's Departments of Family Medicine and Psychiatry to strengthen educational programs and foster collaborative research.

Description: Each Department has identified a coordinator who, with three other members of each Department, comprise a steering committee which meets quarterly to exchange information on developments and new projects in each Department, do some collective problem-solving, if necessary, and to guide new collaborative activities. The coordinators report to their respective chairs after each steering committee meeting.

The collaboration surveyed members of both Departments to identify areas of interest related to shared care, projects currently underway and opportunities identified by faculty. The initial priorities have been the development of an additional year of training in psychiatry for both Family Medicine residents and family physicians looking for extra training, the establishment of joint educational rounds, and the identification of a specific focus for research that will bring together colleagues from both Departments. To date, three joint rounds have been held, a program has been developed for a family physician returning for a year of additional training and a working group seeking to identify a focus for a research project in depression and chronic illness has been struck.

Lessons Learned: The Collaboration has played an important role in increasing knowledge of each other's Department and provided a forum for collaborative problem-solving and planning. Support from the Department Chairs has been essential in getting the collaboration underway. After the initial stage / exchange of information, it is important to have an active focus for activity to maintain momentum.

Contacts: Dr. Nick Kates, 40 Forest Avenue, 2nd floor, Hamilton, ON L8N 1X1
Tel: (905) 521-6133 Fax: (905) 521-6107 e-mail: nkates@mcmaster.ca

Dr. Allyn Walsh, Stonechurch Family Health Centre, 549 Stone Church Rd. E.
Hamilton, ON L8W 3L2
Tel: (905) 575-1300 Fax: (905) 575-0779 e-mail: walsha@mcmaster.ca

Mental Health Evaluation & Community Consultation Unit (MHECCU)

Sponsoring Organizations: University of British Columbia
British Columbia Ministry of Health

Starting Date: 1999

Goals: To undertake health service research to support an improved mental health system;

To measure system performance to assist health authorities in system evaluation;

To enhance the provision of psychiatric outreach services, using an augmented, multidisciplinary approach;

To provide community program support and training to improve local capacity, develop multi-year training plans and recruitment and retention initiatives;

To train providers in underserved areas in advanced clinical skills in mental health;

To support work in the area of best practices;

To support an improved network of emergency mental health response services;

To support the development of an improved communication network that supports the effective delivery of mental health services, including telepsychiatry services.

Description: In June 1999, MHECCU, Department of Psychiatry, UBC initiated a Shared Care Training Committee, whose purpose is to support optimal training for psychiatrists and family physicians in shared mental health care at the University of British Columbia. The Committee meetings involve brainstorming, practical planning, developing and publication of an implementation plan and evaluation plan. Additional input and feedback will be obtained from the B.C. Psychiatric Association, BCMA and residents from both programs before a report is finalized.

Contact: Dr. Elliot Goldner, Head, Mental Health Evaluation & Community Consultation Unit, St. Paul's Hospital, 1081 Burrard Street, Vancouver, B.C. V6Z 1Y6
Telephone: (604) 682-2344

Collaborative Mental Health Network - A Medical Community at a Distance

Sponsoring Organization: Ontario College of Family Physicians

Funding: Ministry of Health and Long-Term Care (for three years as an annual renewable operating and research fund)

Other Participants: Ontario College of Family Physicians
Department of Family and Community Medicine, University of Toronto
Department of Family Medicine, McMaster University
St. Joseph's Health Centre
Hamilton HSO Mental Health & Nutrition Program

Resources: 100 family physicians, 11 psychiatrists, and 9 FP-psychotherapists

Starting Date: March 15, 2001

Rationale: Throughout the province of Ontario, there is a serious shortage and an uneven distribution of psychiatrists, resulting in long waiting lists for access to psychiatrists. Family physicians have come to rely on Emergency Department Crisis Teams for support in emergent situations, but remain responsible for care for the remaining patients, often without access to guidance and advice. The Collaborative Health Network will provide family physicians with access to a psychiatrist and a FP-Psychotherapist.

Goals: To enhance family physician satisfaction with mentor-mentee relationships on mental health care issues;

To improve patient adherence to recommended medical and psychosocial interventions, including Community Treatment Orders;

To reduce the waiting time for psychiatric consultation;

To reduce the time to optimal treatment (as reported by the treating physician);

To increase GAF scores in individuals with severe and persistent mental illness;

To ameliorate patients' symptoms and/or improve patients' interpersonal relations.

Specific objectives are:

To enhance the quality of mental health care provided by family physicians to low and high service utilizers and/or the seriously mentally ill, as defined by the treatment goals of the program;

To support family physicians in the provision of mental health care services in accordance with mental health reform, including Brian's Law;

To provide the means for improving collaboration between psychiatrists, FP-psychotherapists and family physicians;

To provide mental health care CME as required and as defined by the needs assessment;

To monitor the success of the program as defined by the goals and by physician mentee satisfaction.

Description: A Steering Committee completed a needs assessment, designed the network, sought funds for the project and developed a symposium to introduce the participants to the program and to design tools to facilitate communication amongst mentors and mentees. The Collaborative Mental Health Network includes eleven psychiatrists and nine FP-Psychotherapists who are paired into ten teams working with ten family physicians each. The Network is in the process of launching a website with secure e-

mail for individual case consultation, general support for dealing with mental health issues and CME.

Implications: This project will support family physicians in the delivery of enhanced mental health services to patients by providing family physicians with ready access to specialists through teleconferencing, e-mail and face-to-face meetings. A website will provide information and interactive CME and opportunities for small-group learning.

Contacts: Dr. Patricia Rockman, 1466 Bathurst Street, Suite 306, Toronto, ON M5R 3S3
Tel: (416) 536-5555 Fax: (416) 536-3352
e-mail: lusciousabundance@on.aibn.com

Ms. Jan Kasperski, Executive Director, Ontario College of Family Physicians,
357 Bay Street, Mezzanine, Toronto, ON M5H 2T7
Tel: (416) 867-9646 Fax: (416) 867-9990 e-mail: ocfp@cfpc.ca

Reference: Collaborative Mental Health Project - A Medical Community at a Distance: Report to the Ministry of Health and Long-Term Care. February 26, 2001.

Enhanced Skills Program in Mental Health for Family Physicians in British Columbia

Sponsoring Organization: Division of Mental Health, Ministry of Health, B.C. provides funding on an ongoing basis for family physician training and central staff support.

Resources: There is a Program Director (0.2 FTE). Mentors work on a voluntary basis.

Starting Date: 1999

Goals: To increase the skills of family physicians in assessing and managing mental health problems in their communities;

To train family physicians to take on jobs in mental health environments (outpatients, inpatients), where psychiatrists are inaccessible or unnecessary.

Description: Family physicians in any area of British Columbia are invited to apply for funding to pursue areas of personal interest. There is no preset curriculum, rather a curriculum is defined with specific goals and evaluation criteria by the individual student, in consultation with the Program Director. Students may wish to do a few weeks or several months of full-time training, or half-days of training within or close to their own communities for a given period of time.

Regional Mental Health Directors are asked to advertise the Program in their communities and to liaise with the MHECCU Executive Director concerning community needs. The acceptance criteria are as follows:

(i) First priority is given to community physicians who seek to develop enhanced skills to meet and identify community need, and who intend to return to that specific community;

(ii) Second priority is given to community physicians and current residents interested in developing enhanced skills, and links to a specific community with an identified need for those skills;

(iii) Last priority is given to community or resident physicians who have an interest in developing specific enhanced skills, but without an identified community in need of those skills at the time of application.

Successful candidates are asked to keep a log of learning experiences and to document success in meeting their objectives. They are also asked to develop new learning objectives over the course of the training. Physicians in training are asked to do a one-year post-education evaluation to determine how the skills learned have been put into practice.

Mental Health Enhanced Skills Training follows adult learning theory, including student-centred learning objectives, flexible training opportunities designed to meet individual learning needs, and reflective evaluation techniques, rather than formalized testing.

MHECCU hopes to develop an ongoing network of support for learners, involving electronic communication among learners, and, hopefully, connection with MHECCU's outreach programs in local communities.

Key Findings: The learners who have participated in this Program so far have had a wide array of interests, matching the needs of their local communities. Interests have included adult inpatient psychiatry, inpatient geriatric psychiatry, emergency services, counselling services, understanding movement disorders, drug addiction, support for survivors of torture, and general outpatient care.

Students have requested times ranging from four months to sixty half-days of training per year.

Lessons Learned:

Flexibility in scheduling is absolutely paramount given the need for participating physicians to find replacements for their own practices while they are learning.

Difficulties Encountered:

To date, the Program has not been sufficiently well advertised, and there has been underuse of the available resources. Collaboration with Mental Health Directors needs to take place to better advertise the Program, and to ensure that physicians are able to make the best use of their enhanced skills, once they complete their training.

Family physicians have indicated that although they may be interested in this Program, they are so overwhelmed by their busy schedules and patient demands that they are unable to participate.

Feedback has been received that Program participants are not necessarily being supported in their local regions to do sessional contract work, and work on a fee-for-service basis in this area is not viable.

Contact:

Dr. Martha Donnelly, Division of Community Geriatrics, Department of Family Practice, Faculty of Medicine, c/o Stat Centre, Vancouver Hospital & Health Sciences Centre, 715 West 12th Avenue, Vancouver, BC V5Z 1M9
Tel: (604) 875-4461 Fax: (604) 875-5593 e-mail: marthad@unixg.ubc.ca

Telemental Health Service

Sponsoring Organizations: Alberta Mental Health Board
Alberta We//net

Resources: Approximately ten psychiatrists and two psychologists participate in the program, as well as support and research/evaluation staff. The program has access to other disciplines and teams as required.

Starting Date: 1996

Rationale: Telepsychiatry was identified as a strategy to help meet the need for psychiatric services in rural areas.

Goals: To enhance access to specialist mental health resources;

To develop a quality service which makes the best use of available resources.

Description: Telepsychiatry is a system of videoconferencing which uses computers, telephone networks, television screens and video equipment linked together to provide interactive face-to-face communication.

A pilot project was developed in 1996 in response to the scarcity of resources in central Alberta. The focus of the service was the provision of psychiatric consultations to clients referred by general practitioners (GPs). A consultative service model was selected to provide support and assistance to GPs in the management of their clients. Equipment was located in general hospitals where the necessary infrastructure and support were available.

Scheduled services offered include general psychiatry, pediatrics, psychogeriatrics, brain injury rehabilitation and addictions. Other disciplines and teams are also accessible. Psychiatrists are available by telephone to discuss issues. Physicians may attend video consultation appointments with their clients. The service also provides CME educational presentations on a variety of mental health topics via videoconferencing. Virtual luncheons have been arranged to discuss the service and treatment model with referring physicians.

There have been several expansions and 30 sites currently receive services (clinical or educational or both) from the Telemental Health Service.

Key Findings: 96% of referring physicians report being either very satisfied or satisfied with the overall service. 87% of referring physicians reported that the Telemental Health Service has improved their ability to manage psychiatric patients locally.

Contacts: Dr. Douglas Urness, Clinical Director, Telemental Health Service
e-mail: Doug.Urness@amhb.ab.ca

Sharlene Stayberg, Administrative Director, Telemental Health Service
Tel: (403) 783-7736 e-mail: Sharlene.Stayberg@amhb.ab.ca

Publications: Hailey D et al. An Assessment Framework for Telemedicine Applications. Journal of Telemedicine and Telecare 1999; 5:162-170.

Dose S et al. Evaluation of a Telepsychiatry Pilot Project. Journal of Telemedicine and Telecare 1999; 5:38-46.

Urness D. Telepsychiatry and the Alberta Experience. CPA Bulletin April 1999.

Urness D. “Evaluation of a Canadian Telepsychiatry Service”, The Impact of Telemedicine on Health Care Mangement. Nerlich M and Kretschmer M (Eds), IOS Press, 1999.

Family Help: Evidence-Based, Distance Treatment for Primary Care Mental Health

Sponsoring Organizations:	Nova Scotia Health Districts 3, 4 and 5 Dalhousie University IWK Grace Health Centre
Funding:	Community Alliance for Health Research (CAHR) program of Canadian Institutes of Health Research (CIHR)
Starting Date:	March 31, 2001
Goal:	To develop a primary care mental health option for children and families.
Description:	The Family Help CAHR is designed to initiate a research-driven revolution in the delivery of primary care mental health to children and their families. The objectives are: To test the feasibility of and revise six Family Help modules giving state-of-the-art psychological treatment of psychosocial and behaviour problems in children using a distance education model of treatment in close cooperation with family physicians; To evaluate the modules, using randomized trials, in comparison with usual care in terms of reduction in symptoms, reduction in disability or increase in quality of life, cost to the health care system, cost to the families, and patient, family and primary care physician satisfaction; To initiate investigation of the factors influencing successful treatment; To develop clinical and research training opportunities for clinicians and students in both the social and health sciences.
Difficulty Encountered:	With persistence, funding was obtained.
Contact:	Dr. Peter J. McGrath, Professor of Psychology, Pediatrics, Psychiatry and Biomedical Engineering, Dalhousie University and IWK Grace Health Center e-mail: pmcgrath@is.dal.ca

Clinical

Studies of the relationship between primary care and mental health services have identified similar problems with access to mental health services, poor communication between the two specialties and lack of support for the family physicians in their role as mental health provider. This section describes innovative programs that are changing the day-to-day working relationship between mental health and primary care services. Between them, these projects have managed to address these problems and eliminate some of the barriers to well-coordinated and continuous care.

These projects can be broken down into four broad groups. The first are initiatives taken by many existing mental health programs to improve access to mental health care. For the most part, these programs have achieved this by simplifying access or by promoting a more rapid response to requests from family physicians. There are also examples of guides developed for family physicians to keep them informed about relevant community resources for their patients.

A natural step in the evolution of this model has been the shift towards delivering mental health services in primary care settings rather than mental health clinics. A number of the programs that have successfully achieved this comprise the second group in this section. Some involve a psychiatrist going into a mental health clinic for brief periods of time over the course of a month. In some, small interdisciplinary teams of mental health providers visit primary care settings on a regular basis. There are also an increasing number of programs which have successfully integrated counsellors and psychiatrists within primary care settings as part of the primary care team.

While most of these projects have been established fairly recently, in some places, such as Quebec's CLSCs and Community Health Centres across the country, this kind of collaboration has been working well for many years. While the scope and resources available for these programs vary greatly, there are many similarities in their goals and the principles that guide them.

The third group of programs has targeted particular populations whose needs are not being met by current models of service delivery, such as ethno-cultural groups and the homeless. Many of these groundbreaking projects offer important lessons to other providers looking at new ways of addressing problems that traditional services have not been able to resolve.

Finally, there is a group of programs that has developed models for delivering service to underserved areas. These are usually based around visits to the community by a psychiatrist from another part of the same province who functions not only as a consultant, but also as a resource to other providers in that community, particularly family physicians. This section also includes descriptions of programs developed in larger centres to coordinate outreach psychiatric services to more isolated communities. Of particular interest are projects where family physicians are working in psychiatric services, including inpatient units. These models are likely to receive greater attention, particularly in communities with difficulties recruiting psychiatrists.

B.C. Mental Health Guide

Sponsoring Organization:	Division of Mental Health, Ministry of Health After the launch, support for updating will be provided by MHECCU.
Starting Date:	The Resource Guide was launched March 31, 2001.
Goal:	To develop an online web directory containing up-to-date information about mental health resources throughout British Columbia.
Description:	The Guide is a general mental health resources guide, including adult mental health centres, child and youth mental health services, hospitals, psychiatric services, mental health societies and associations, and mental health self-help groups. The Guide has simple, advanced, alphabetic and keyword search capacities. At launch, there will be two links to other website directories, although that number may increase in the future. At the end of the website, users will have an opportunity to comment on ease of use and make suggestions for future improvements. The guide can be accessed at the following website: http:\\www.mheccu.ubc.ca\resourceguide\
Difficulty Encountered:	This website directory was launched at the end of March 2001. It is uncertain how much ongoing maintenance will be required to keep the Guide up-to-date, making it difficult to plan for future need. This will have to be judged over time.
Contact:	Lori Seidelman e-mail: resourceguide@mheccu.ubc.ca

Family Physician's Guide to Community Resources

Sponsoring Organization: The guide was prepared by the Hamilton HSO Mental Health & Nutrition Program, in conjunction with Hamilton's Community Information Service, District Health Council and Regional Psychiatry Program.

Starting Date: 1991 (the fourth edition was published in 2001)

Rationale: Physicians frequently complain about the difficulty of obtaining helpful information on available local mental health and related resources for their patients. Existing guides are either hard to use, too large to carry about the office or out-of-date.

Goal: To produce an easy-to-use problem-based guide for family physicians that would enable them to gain ready access to local services of benefit to their patients.

Description: The Guide provides a compact, pocket-sized booklet with services categorized by the kind of problem the family physician might encounter. Headings include mental health problems in adults, children's problems, addictions, legal issues, housing, finances, self-help groups and the needs of special populations such as the elderly or developmentally-delayed individuals.

Each section lists services by the nature of the problem (i.e., for addictions - acute detoxification, inpatient treatment for addictions, outpatient programs and support groups) and provides specific information that will assist the family physician in making the referral - the phone number of the intake worker, hours of operation of intake, whether a self-referral is possible, any costs involved, and other tips on how best to use the service. The front page lists emergency telephone numbers and crisis lines.

Lessons Learned: The booklet has been extremely well received, not only by family physicians, but by community groups and other providers of mental health services, all of whom see a need for ready access to information on community resources. To ensure that data remains current, the booklet has been reprinted every three years with a circulation of 2,500 copies each time.

Difficulty Encountered: The major difficulty has been ensuring the information remains up-to-date. Approximately 25% of entries change every three years.

Implications: Family physicians appreciate having ready access to relevant, up-to-date and easy-to-use information on local resources. Similar guides can be produced in most communities.

Contact: Sheryl Farrar, 40 Forest Avenue, 2nd floor, Hamilton, ON L8N 1X1
Tel: (905) 521-6133 Fax: (905) 521-6107 e-mail: farrars@mcmaster.ca

Development of a Consultation Form Specific to the Family Doctor/Psychiatrist Consultation Process

Sponsoring Organization:	St. Mary's Hospital Centre, Montreal
Resources:	The hospital-based Psychiatry Department is comprised of 13 psychiatrists and 3 psychologists. The Department of Family Medicine has 128 active physicians. Psychiatric services are sectorized and referrals can also come from non-hospital-affiliated doctors.
Starting Date:	1994
Goal:	To develop a form for a psychiatric consultation that supplied the consultant with the necessary background information required to make a comprehensive assessment, and supplied the family physician with information that was comprehensive enough to assume ongoing care of the patient post-consult.
Description:	An interdisciplinary committee met over an 18-month period to improve the consultation process from family physician to mental health consultant. It examined definitions of what the words consultation, referral and transfer of care meant; modalities to define urgent, acute, transient, or chronic care; what family doctors and psychiatrists each considered important in the consultation process; and criteria for triage of consultations.
Key Findings:	A discipline-specific consultation form was generated, for either handwritten or dictation format, and was incorporated into daily usage.
Difficulty Encountered:	Even while acknowledging the improvements derived from the discipline-specific form, when added to the myriad of other forms found in a doctor's office, a number of doctors reverted to a generic consultation form.
Implications:	An improved understanding of the needs of family doctors and psychiatrists was derived from this work. Greater acceptability of the new form was felt to be possible if other disciplines also created their own discipline-specific form, so that generic forms would disappear.
Contact:	Dr. Mark Yaffe, Chief, Department of Family Medicine, St. Mary's Hospital Centre, 3830, avenue Lacombe, Montreal, QC H3T 1M5 Tel: (514) 734-2677 e-mail: myaffe@po-box.mcgill.ca

Bipolar Treatment Optimization Program (BiTOP)

Sponsoring Organizations: Centre for Addiction and Mental Health
University of Toronto

Funding: The Program receives funding from the Ontario Mental Health Foundation and a private donor fund (Margaret Botterell Bipolar Project, CAMH Foundation). Clinical treatment is funded as usual through OHIP and Ministry of Health & Long-Term Care.

Resources: The Program has 1 part-time equivalent psychiatrist, 1 part-time social worker, and 1 part-time occupational therapist. A central team comprised of a part-time director, 1 full-time and 1 part-time research assistant, and support staff coordinate the program.

Starting Date: January 2000

Goals: To provide time-limited 'best-practices' care to patients;

To teach such 'best-practices' care to primary care physicians through an educational/health system intervention so that physicians may continue to treat the individual with bipolar disorder in a primary care/community setting;

To create and maintain links between mental health and primary care services;

To support the role of primary care providers in delivering mental health care.

Description: The Bipolar Treatment Optimization Program (BiTOP) is a novel pilot program which simultaneously 'admits' both patients with bipolar disorder and their treating family physician to parallel interventions designed to improve the health of patients and the skill base of practitioners.

The patient intervention involves initial comprehensive assessment by a multi-disciplinary team including psychiatry, occupational therapy, and social work. This assessment leads to specific treatment recommendations on medications, psychoeducation, psychotherapy, family interventions, and occupational therapy approaches, with careful attention to planning such treatment in terms of timing of interventions, and identification of relevant community resources. The clinical intervention by specialist tertiary mental health staff is limited to approximately six months, following which medication treatment reverts to the family physician with the psychiatrist in a 'backup' consulting role, and other treatments (i.e. psychotherapy, occupational therapy) continuing as necessary in community settings.

The family physicians of these patients receive an educational assessment and educational recommendations from a specialist in continuing medical education. Furthermore, the family physicians are offered educational materials and programs for all mood and anxiety disorders, together with regular access to the treating psychiatrist to enhance communication links and mentoring for a one-year period.

In this initial phase of the study, both patients and physicians are participating to identify the feasibility of the program. Patients are assessed by an independent rater monthly on a variety of clinical and functional scales, as well as for satisfaction with the intervention. Similarly, the family physicians are monitored regularly on their participation in educational programs, their use of communication opportunities with the psychiatrist, knowledge of bipolar disorder, self-rated skills in managing mood and anxiety disorders, and overall satisfaction with the program.

Key Findings: During this pilot phase, 25 patients and 20 family physicians have joined the program. Initial results suggest that both patients and their family physicians will enroll in such a program, and that both groups are very committed to continuing the program.

Preliminary clinical appraisals suggest improvement in patient symptoms and functioning, coupled with good compliance with treatment.

Implications:

Providing a mix of patient and provider interventions allows more mental disorders to be treated in the primary care setting, especially a difficult disorder such as bipolar illness.

Contacts:

Dr. Sagar Parikh, Centre for Addiction and Mental Health
250 College Street, Toronto, ON M5T 1R8
Tel: (416) 979-6946 Fax: (416) 979-6864 e-mail: sagar_parikh@camh.net

Reena Chopra, Centre for Addiction and Mental Health
250 College Street, Toronto, ON M5T 1R8
Tel: (416) 535-8501 ext. 4357 Fax: (416) 979-6864
e-mail: reena_chopra@camh.net

Lisa Norton, Centre for Addiction and Mental Health
250 College Street, Toronto, ON M5T 1R8
Tel: (416) 535-8501 ext. 4167 Fax: (416) 979-6864
e-mail: lisa_norton@camh.net

Vancouver/Richmond Health Board Shared Care Program in CHA#6 (South Mental Health Team)

Sponsoring Organization: Vancouver Community Mental Health Services, Vancouver/Richmond Health Board

Resources: One new permanent 0.8 FTE nursing position, funded by the Vancouver/Richmond Health Board, was created for this program.

Starting Date: January 2, 2001

Goals: To establish closer liaison with family physicians in the South Mental Health Team's boundary;

To be more responsive to the community with a focus on the clients and their families;

To improve efficiency of resource use within the Adult Component of the South Mental Health Team.

Description: An advisory working group was set up. The group met with Health Records, and conducted evaluation/research planning. A mission statement, goals and objectives, protocols and guidelines were developed. In January and February 2000, each Adult Component clinician met with the team director and the senior mental health worker to review caseloads and identify shared care clients.

The Program provides support for stable South Mental Health Team clients (Exit Treatment Group) as they are transferred to the care of their family physician, as well as providing consultation to clarify a diagnosis, support in establishing a treatment plan, and/or short-term treatment, as requested by the family physician, for clients who will return to the care of their family physician once they are stable.

The program has now begun accepting cases for consultation and/or short-term treatment. The program will attempt to provide psychoeducational materials to the 174 family physicians in the South Mental Health Team service delivery area, as well as to family physicians outside the area providing treatment to shared care clients.

Difficulty Encountered: The nurse who was originally hired resigned after two months of work. The program restarted in June 2001 after a new nurse was recruited.

Contact: Ms. Eva Ho, Director, South Mental Health Team
Vancouver/Richmond Health Board
220 - 1200 West 73rd Avenue, Vancouver,B.C. V6P 6G5
Tel: (604) 266-6124 Fax: (604) 266-7134 e-mail: eva_ho@vrhb.bc.ca

The Alumni Program: A Follow-Up Shared Care Program

Sponsoring Organization: Psychotic Disorders Clinic (PDC), Hamilton Health Sciences Corporation, McMaster Site

Funding: The Alumni Program has been incorporated into the regular clinical functioning of the Psychotic Disorders Clinic. It is situated in a hospital Outpatient Department and staff are hospital employees.

Starting Date: 1992

Rationale: The population of persons with severe mental illness is very diverse, with a consequent need for a range and a variety of approaches to community care, tailored to the specific needs of individual clients. As well, there are not enough case-management placements in the region for all persons with severe psychiatric disorder. Not all persons with severe mental illness need Assertive Community Treatment. The Psychotic Disorders Team felt that certain clients could learn excellent self-care, and do well in shared care provided by a partnership of family practice with the specialized psychiatric team. For these clients, the Alumni Program can provide the right treatment at the right time in the right place at the right cost.

Goals: To provide continuity of support to clients and their families over the entire course of their illness;

To support clients in attaining their health maintenance goals;

To share care effectively with general practitioners, providing specialist psychiatric services when appropriate;

To reduce the propensity for client dependence on “the system”;

To provide continuous support to general practitioners and certain case management services;

To support a large number of clients.

Description: The Alumni Program is a model of continuing care treatment involving shared care between family practitioners and the Psychotic Disorders Clinic. Participants in the program (“alumni”) have completed a period of active treatment with the Psychotic Disorders Clinic, have attained a level of self-care competency, and remain in treatment with their Family Practice physician, with “backup” from the Psychotic Disorders Team.

Alumni attend the clinic for regular six- to twelve-month visits, and are welcome to re-enter the clinic for renewed active treatment, as indicated and negotiated. They may also receive concurrent support from case management services. Participation by family, friends and community workers is welcome, if the client wishes. There is quick access to the Clinic by the alumni and the family practitioners.

For family practitioners, the Clinic provides same-day return of phone calls, offering telephone advice, urgent appointments to alumni (on the same day or within a week, as necessary), timely written reports/letters after each alumni visit, and collaboration if clients develop a physical condition which affects their psychiatric care. 115 alumni currently participate in the program, and data have been collected on their marital status, employment status, living situation, diagnosis and other factors.

Key Findings: The majority of alumni have sustained good insight, and their BPRS (symptoms) and Global Assessment of Functioning (GAF) have remained unchanged or improved over time. The total number of inpatient admissions has decreased from 203 prior to transfer to alumnus status, to 14 after transfer to alumnus status. There have been 3 Emergency Room visits by alumni, and 2 suicide attempts (0 completed). 32% of

alumni take typical anti-psychotic medications, 58% take atypical anti-psychotics, and 10% take no current anti-psychotics but take other psychiatric medications. In general, alumni enjoy good social and family support, and live either independently or with family members. They are generally well educated, engaged in meaningful work and non-substance-abusing. Alumni are excellent partners in treatment, adhering to the negotiated treatment plan.

Lessons Learned:

Many persons with psychotic disorders need ongoing intensive support and treatment such as that offered by ACT case management programs. There is, however, a group of individuals with severe psychiatric disorders who can learn good self-care (self-monitor their mental well-being, take medications, utilize good stress management techniques, maintain a good working relationship with their general practitioner and seek professional psychiatric help when needed), and can successfully engage in a shared care model of follow-up treatment such as the Psychotic Disorders Clinic Alumni program. This shared care model has reduced hospital resource utilization, making it cost effective.

Difficulties Encountered:

There has been a 10% (n = 11) dropout rate over the course of nine years. With no method of tracking dropout clients, no information is available about their health and well-being since discharge from the Clinic.

Implications:

The sharing of care in the Alumni Program provides continuing support to family physicians for the management of psychiatric clients, while enabling the psychiatric team to focus on treating the acutely ill, and those actively engaged in rehabilitation.

Contact:

Heather Hobbs, Coordinator, Psychotic Disorders Clinic
3G Out-Patient Psychiatry, McMaster University Medical Centre
1200 Main Street West, Hamilton, ON L8N 3Z5
Tel: (905) 521-5018 Fax: (905) 521-2628

References:

Hamilton Wilson J, Hobbs H. Therapeutic Partnership: A Model of Clinical Practice. Journal of Psychosocial Nursing and Mental Health Services 1995; 33: 27-30.

Hobbs H, Hamilton Wilson J, Archie S. The Alumni Program: Redefining Continuity of Care in Psychiatry. Journal of Psychosocial Nursing and Mental Health Services 1999; 37(1):23-29.

Shared Care Services, Community Mental Health

Sponsoring Organization: St. Joseph's Health Centre

Funding: There is global funding through St. Joseph's Health Centre. Psychiatrists are funded on a fee-for-service basis. Permanent funding by the Ontario Ministry of Health and Long-Term Care will begin in April 2001. This funding will provide for additional mental health clinicians, a team coordinator, sessionals and clerical support, and will enhance outreach services and help develop understandings with supportive housing and community health centres.

Starting Date: The shared care model at St. Joseph's Health Centre was initially piloted with an intramural academic Family Medicine Department from December 1998 through October 1999.

Rationale: Family physicians have long been the backbone of the mental health system. Most people suffering from mental illness do not need direct psychiatric care. With support from psychiatric specialists, patients can be treated in their own community by their own doctors.

Goals: To provide improved and quicker access to mental health consultation;

To build relationships with family doctors in order to help them provide continuing care for patients with mental illnesses;

To serve a greater number of clients, in order to better support the mental health of the community;

To evaluate the shared care model and its applications;

To pilot shared care with severely mentally ill patients and their families;

To contribute to the education of family physicians and psychiatrists.

Description: The Shared Care Services Program is a collaboration between primary care physicians and psychiatric specialists working together for their patients' treatment. Referrals to the Program are made by the primary care physician. The client attends a pre-assessment interview, conducted by a mental health clinician, as well as an assessment interview, conducted by a psychiatrist and a mental health clinician. Upon completion of the psychiatric assessment, the information is shared with the client and a comprehensive consultation report is sent to the primary care physician.

The Program provides the primary care physician with a comprehensive biopsychosocial assessment, a confirmation of the patient's diagnosis, treatment recommendations that identify a medication regime and community resources appropriate to the needs of the clients, and the availability of ongoing consultation/reassessment of clients. Telephone consultations with a psychiatrist are available, as are brief follow-ups for clients when necessary.

The Program provides educational experiences for University of Toronto Family and Community Medicine residents, and is available to Psychiatry residents as an elective.

A database is being developed which will catalogue demographics, clinical profiles and service issues to help with future planning.

Key Findings: Family Medicine staff doctors and residents expressed a high level of satisfaction with the Program, resulting in the Shared Care Team's expansion of services to community-based family doctors.

Lessons Learned: Primary care physicians and mental health specialists working collaboratively can effectively address the mental health needs of patients in the community.

Implications: This model of care improves accessibility to mental health care, establishes more effective communication and working relationships with family doctors, and increases family doctors' knowledge base and comfort level regarding mental health care and community services.

Contact: Ms. Vicky Nicholson, Manager, Community Mental Health
St. Joseph's Community Mental Health Services
SWW 4th Floor, 30 The Queensway, Toronto, ON M6R 1B5
Tel: (416) 530-6000, ext. 3395 e-mail: nichov@stjoe.on.ca

Urgent Consultation Clinics (The Ottawa Hospital, General Campus and The Ottawa Hospital, Civic Campus)

Sponsoring Organization: Department of Psychiatry, The Ottawa Hospital

Funding: Fee-for-service and some sessional funding from the Ministry of Health and Long-Term Care (psychiatrists); hospital outpatient psychiatric program funding provided for mental health program staff.

Resources: The program has 1.4 FTE outpatient psychiatrists (involving 7 psychiatrists in total), 3.5 FTE psychiatric nurses, 0.5 FTE social worker and 2.0 FTE psychologists.

Starting Dates: July 2000 (General Campus)
March 2001 (Civic Campus)

Goals: To improve access to urgent psychiatric consultation and short-term follow-up for patients seen in the Emergency Department, those referred by physicians and surgeons within the hospital, and patients referred by community family physicians;

To provide an outpatient psychiatric assessment within one week of referral, and possible short-term follow-up by a psychiatrist, psychiatric nurse, and/or psychiatric social worker.

Description: Approximately 10 to 15 new patients in total are seen each week in the urgent consultation clinics at both campuses. Patients seen and discharged from the psychiatric emergency service are given priority for follow-up at the urgent consultation clinics. All patients are initially seen by a psychiatric nurse and psychiatrist jointly. Individual follow-up is provided by a psychiatric nurse and psychiatrist for 6 to 8 sessions (i. e., usually over 4 to 6 weeks). Short-term group therapies have recently been set up, focusing on interpersonal support for patients with depression/anxiety disorders. Individual short-term cognitive behavioural therapy is also offered (6 to 8 sessions). A close liaison exists with our acute day hospital programs which also operate at each campus - patients seen in the urgent consultation clinic may be referred to the acute day hospital after their initial assessment, if intensive outpatient follow-up is indicated. During the time seen at the Urgent Consultation Clinic, contact with the patient's family physician is established and arrangements are made for follow-up. If the patient does not have a family physician, then referral is made and an appointment is secured. Psychiatric backup to the family physician after discharge from the clinic is made on an informal basis with the psychiatrist or psychiatric nurse.

Key Findings: Outcome measures and patient satisfaction measures have not yet been developed, but will be put in place within the next year.

Difficulties Encountered: Psychiatrist recruitment has been a limiting factor for establishment of the clinic at one campus, until recently. Conversion of a long-term day treatment program (4 to 6 months) to an acute day hospital (4-week program) has just occurred at one campus, and has been in place at the other campus for one year. Some outpatient psychiatrists were initially reluctant to work in multidisciplinary teams, and share clinical responsibility for patients. Due to volume of patients referred by the psychiatric emergency service, access by community family physicians has been limited. One campus lacks an essential social worker position, soon to be filled if funding is available. There is little sessional funding to allow adequate indirect care/education with family physicians. No psychiatrist has enough sessional funding, and there are no nursing or other counsellors to provide visits to family physicians' practices, as in a true shared care model.

Implications: The urgent consultation clinics at the Ottawa Hospital have been set up to provide rapid access to psychiatric care for patients seen and discharged from the psychiatric

emergency service, and for limited numbers of patients referred by hospital-based physicians and community family physicians. To allow for development of a true shared care model, there must be adequate psychiatrist staffing, enough sessional or alternative funding to allow psychiatrists to work with family physicians providing education and indirect care, and funding to allow for mental health counsellors to be integrated into a primary care team. The urgent consultation clinics thus represent an initial step to improve access to mental health care for outpatients of the Ottawa Hospital, but further development of mental health shared care practice is required in Ottawa.

Contact:

Dr. Robert Swenson, Director of Outpatient and Community Psychiatry
The Ottawa Hospital, Box 400, 501 Smyth Rd., Ottawa, Ontario K1H 8L6
Tel: (613) 737-8083 e-mail: jrswenson@ottawahospital.on.ca

Programme de Soins Partagés en Psychiatrie (PSPP)

Sponsoring Organizations: Département de Psychiatrie, Centre Hospitalier Universitaire de Montréal (CHUM)
Département de Psychiatrie de l'Université de Montréal
Association des Médecins Psychiatres du Québec

Resources: Four psychiatrists, one family physician, who acts as a liaison between Family Medicine and Psychiatry, and one nurse are involved in the program.

Starting Date: Project planning began in June 1998; the clinic opened in October 1998.

Goals: To improve patient care;

To facilitate links and collaboration between the family physicians, the psychiatrists and the network;

To speed up access to required services;

To coordinate efforts in health care reorganization;

To improve the early detection of mental disorders;

To integrate psychiatry and primary care;

To improve CME;

To give mutual support to mental health care providers;

To move towards a complementary care system;

To make the best use of everyone's abilities;

To diminish the impact of an untreated or undetected mental disorder;

To improve the quality of psychiatric care at the primary care level.

Description: The program offers rapid (usually within 7 - 10 days) psychiatric consultation to patients referred by their family physicians. There is no long-term follow-up, but there can be more than one appointment to complete an evaluation or to re-evaluate the status of a previously-seen patient. The program operates at Notre-Dame Hospital, CHUM, but will also provide home evaluation, or consultation at the family physician's office, if necessary.

In the planning stages of the program, staff met with the University Committee of Family Physicians and Psychiatrists on shared care, the Committee of the Quebec Psychiatrists' Association on shared care with general practitioners, and the Regional Health Board's Committee on Shared Care in Montreal. Meetings, weekend conferences and training sessions were held to present and explain the project to physicians and CLSC staff. A conference entitled "The Psychopharmacology Challenge" was organized for family physicians and general practitioners.

A committee was established with the family physicians of the Faubourgs CLSC and the PSPP for training and consultation and training rotations were established for residents in Family Medicine and Psychiatry. Numerous meetings were held to present the PSPP project across the province.

A "health logbook" (patient's medical passport) was formulated to be distributed in the province.

A seminar for shared care in psychiatry was developed for Psychiatry residents (one time/two months).

Key Findings: To date, 350 patients have been assessed by the team. The majority of patients came from local CLSCs and from private clinics. The reasons for referral were primarily to establish a diagnosis, to clarify a diagnosis or make it more precise, and to suggest a

treatment plan. Recommendations involve the initiation of a medication or its adjustment, individual psychotherapy, and advice on the treatment plan. A sample of 100 patients showed a high proportion of patients with personality disorders. It was also noted that several of the patients had general medical problems.

Communication among all members of the team has improved and become more frequent. Referring physicians have reported high levels of satisfaction with the services provided, as have the clients. Referring physicians have occasionally asked the consulting psychiatrists to review certain particularly complex and difficult cases.

The consulting psychiatrists have referred few people to outside psychiatric clinics. They try in their recommendations to make use of all available resources to meet each patient's needs for treatment and follow-up.

Lessons Learned: Positive aspects of this collaboration include direct dialogue, rapid access, better integration of information, shared caseload, improved utilization of resources, improved detection, mutual support, satisfaction, better coordination of care, better recognition of problems and improved transfer of knowledge and information.

Difficulties Encountered: Obstacles to pre-assessment included the reduced availability of doctors at times, the limited view of the roles of professional disciplines, the lack of knowledge of psychiatry and of available resources, and lack of knowledge of drug addiction. Finding clients was more difficult than anticipated. As well, there was insufficient collection of data of previous patient assessments and chart summaries.

Obstacles to assessment included the failure of the clinic practitioners and shared care psychiatrists to recognize one another professionally; different training and abilities; variable interest on the part of the doctors and the patients; variable skills on the part of the doctors; unclear expectations; inequality of resources in the area; communication problems between the different interviewers (for example, between social workers and doctors); and finally, lack of respect for one another's skills and abilities.

Contact: Dr. Michelle Dumont, PSPP Project, Department of Psychiatry,
CHUM-Pavillon Notre Dame, 1560 Sherbrooke est, 6th Floor,
Montreal, QC H2L 4M1
tel: (514) 890-8000, ext. 26481 fax: (514) 896-4759

Waterloo Region HSO Mental Health Program

Sponsoring Organization: Ontario Ministry of Health and Long-Term Care

Funding: The Program receives funding through the Ontario Ministry of Health and Long-Term Care Alternate Payments Branch.

Resources: The Program has 25 part-time counsellors in addition to the above-named staff. The counsellors are predominantly psychologists or social workers (PhD and MSW). The Program has also included two part-time Registered Dietitians.

Starting Date: October 1994

Goals: To provide comprehensive mental health services to the patients of 60 HSO physicians in 11 practices across Waterloo Region;

To provide an evaluation component evaluating the Program's effectiveness;

To monitor the HSO Program through an extensive quality assurance review;

To provide additional services to the HSO patients by utilizing extended health care benefits and other outside funding sources.

Description: Family physicians fax referrals to the central program office. Telephone intake obtains more information from the patient. Urgent cases are then seen immediately with others seen within two weeks. Therapists work in offices throughout the Region and also at the physicians' offices. Patients are assigned to the therapist with the most expertise in a particular problem area. Therapy utilizes individual, couple, family and also workshop formats.

Small group psychoeducational workshops are regularly offered in areas of stress management, self-esteem, parenting, and anxiety management. Periodically, workshops are offered with respect to attention deficit disorder and for children of separated or divorced parents.

The Program also utilizes community agencies whenever possible, either on a referral or contract basis. Some of the work is case management, seeking the most appropriate service for the client across the community, and then monitoring to ensure that it is received. In this way, existing services are not duplicated and all services can be utilized most effectively. The Program aims to be part of an integrated system.

Mental health screening services have also been offered on a community-wide basis for several years, through participation in National Depression and National Anxiety Screening Days.

Satisfaction and outcome evaluation are conducted every fourth session and at the termination of treatment. Family physicians are regularly consulted and informed as to therapeutic progress.

Key Findings: The Program receives approximately 2300 referrals per year. Client satisfaction has consistently been extremely high. For example, in the last year for which the evaluation has been completed (April 1999 - March 2000) clients reported that the services were generally or highly appropriate (99%), and that their problems had improved - four sessions after the start of treatment (84%). In addition, clients reported that they definitely would or probably would recommend the HSO Program to either a friend or family member who was seeking help (99%). Physician satisfaction with the program has also consistently been very high.

There were significant declines in symptom reporting on the SCL-90R for both male and female clients. The most common presenting problems were depression, anxiety and relational issues.

Cost benefit analyses indicated that the HSO Program provided 18% more services to HSO clients by utilizing extended health care benefits.

Implications:

Community-based professional mental health care is an effective and efficient adjunct to family practice. By working together, mental health professionals and family physicians have been better able to solve problems. Sharing care has resulted in the immense improvement of the clients' overall functioning. Mental health issues were often previously ignored. Family physicians are now generally much more aware of mental health problems and willing to assist in their resolution.

Contact:

Dr. Charles Pierce, Belmont Professional Centre, 564 Belmont Avenue West, Suite 409, Kitchener, ON N2M 5N6
Tel: (519) 742-3101 Fax: (519) 742-6000 e-mail: cpierce@mgl.ca

Lakehead Shared Care Mental Health Program

Sponsoring Organizations: Lakehead Psychiatric Hospital
Fort William Family Practice Clinic

Funding: Funding is currently being sought through a community reinvestment fund. Partial funding has also been provided by the Lakehead Psychiatric Hospital. A third source of funding may include Thunder Bay Regional Hospital.

Resources: Projected time for the psychiatrists would be 1/2 day every two weeks. Up to 2.0 full-time counsellors are in the funding application. It is projected that three counsellors would be required within a year of initiating the program.

Starting Date: April - May 2001 (expected)

Goals: To make psychiatric services available to an eight-physician family practice in Thunder Bay;

To increase access to prompt psychiatric consultation and counselling services;

To support the role of primary care physicians in providing mental health services.

Description: Several meetings have occurred with the physician group to determine counselling needs and available office space. Outcome measures and symptom scales are expected to match those of the Hamilton HSO Program. These include a Depression Scale, a Satisfaction Scale, and Functional Outcome, such as the SF-36.

It is projected that interest in this program will increase in the coming year and other psychiatrists may offer their services. In Thunder Bay, there are several large clinics that have 15 or more physicians working in primary care. It is clear that a successful initial startup would be required before implementing the program in other clinics in Thunder Bay.

Contact: Dr. Jack Haggarty
Lakehead Psychiatric Hospital, P.O. Box 2930, Thunder Bay, Ontario P7B 5G4
Tel: (807) 343-4300 e-mail: jhaggart@uwo.ca

Community Mental Health Consultation Service (CMHCS)

Sponsoring Organizations: C.J.Ranger Mental Health Clinic (North Bay Psychiatric Hospital)
Muskoka Parry Sound Community Mental Health Service

Funding: North Bay Psychiatric Hospital

Resources: Staffing consists of 0.8 FTE psychiatrist, 0.8 FTE CMHCS clinician (psychiatric nurse) and a half-time secretary. A clinical psychologist is also available one day per month.

Starting Date: September 2001

Goal: To facilitate exemplary community-based services and supports for people with mental health disorders, and for their families and caregivers, through collaboration with primary care practitioners in the Nipissing/Temiskaming and northern Muskoka/Parry Sound districts.

Description: The CMHCS services 12 primary care providers (PCPs), located at 2 sites within North Bay and 4 sites in small communities within a 45-minute drive of North Bay. Practice size ranges from 1 - 5 PCPs. The total patient population of these practices is approximately 19,500. Each site is visited by the psychiatrist and clinician bi-weekly. Smaller sites are visited for 1/2 day and larger sites for a full day. Plans are currently underway to expand the CMHCS to include more PCPs within North Bay.

In addition to the use of modified Hamilton HSO Mental Health Program consultation, assessment, and treatment outcome forms, the Threshold Assessment Grid, World Health Organization - Disability Assessment Scale II, Global Assessment Scale, Visit Satisfaction Questionnaire and Client Satisfaction Questionnaire are completed for each patient.

Patients are seen on average for 1 to 2 visits by the psychiatrist and 2 to 4 visits by the CMHCS clinician, prior to an impression and recommendations for ongoing management being provided to the PCP. The PCP may request re-assessment of a patient at any time. Frequent, brief discussions occur, involving CMHCS team members and the PCPs about patients previously assessed by the CMHCS team and /or those the PCP is considering referring to the CMHCS.

Lessons Learned: In the current climate, PCPs are particularly sensitive to any initiatives they perceive to be “another attempt by the Ministry to download more onto us”. Thus, issues such as funding for space to be used by the CMHCS and emphasis on work sharing versus downloading need to be emphasized.

Contact: Dr. David Haslam, C.J.Ranger Mental Health Clinic
200 First Avenue West, North Bay, ON P1B 9M3
Tel: (705) 494-3063 Fax: (705) 494-3092 e-mail: haslam@bigfoot.com

Enhancing Collaboration in Mental Health Services at CLSC des Faubourgs

Sponsoring Organizations:	CLSC des Faubourgs Department of Psychiatry, CHUM
Starting Dates:	Collaboration between the medical team and psychiatrist began in 1996; collaboration with the psychosocial team was added in 1998. The program was on hold temporarily because the psychiatrist formerly involved was no longer available. A new psychiatrist has now joined the program.
Goal:	To improve collaborative care and continuity within the CLSC and with the CLSC's main mental health partners.
Description:	Joint case discussion takes place for two hours every month. Family Medicine or Psychiatry residents involved in teaching activities with the psychiatrist may be integrated into the group to join the case presentation and discussion.
Key Findings:	Access to psychiatric services has improved. The relationships between members of the CLSC staff have improved and deepened, with increased cohesion and respect for one another.
Lessons Learned:	Group cohesion is necessary to achieve a higher quality of discussion. Time is required to decrease participants' feelings of defensiveness about revealing difficult clinical situations.
Contact:	Dr. Sophie Galarneau, CLSC des Faubourgs 2260 Parthenais, Montreal QC H2K 3T5 Tel: (514) 527-4929 ext. 340 e-mail: sogalarneau@hotmail.com

Short-Term Mental Health Evaluation and Follow-Up Program

Sponsoring Organization: CLSC des Faubourgs

Starting Date: September 1999

Goals: To provide better mental health care to CLSC patients by reducing the waiting time for detailed medical evaluation;

To assist physicians in the diagnosis and follow-up of the increasing number of patients with mental health problems seen through the walk-in clinic;

To assist physicians in the treatment of their patients by providing a second opinion before considering a psychiatric referral;

To support health professionals in the CLSC seeking medical advice or evaluation for a client;

To provide rapid pharmacological treatment, when indicated, and permit short-term follow-up of medication while waiting for transfer to long-term follow-up;

To provide short-term follow-up following a crisis, evaluate and agree on the best treatment plan and options for the patient and create a link with known long-term resources in the community.

Description: Three family physicians with a special interest in mental health participate in this program, spending from 1/2 to one day per week seeing patients with mental health problems. Appointments of 1-1/2 to 2 hours are scheduled for a new evaluation, and 1/2 hour appointments for follow-up. Physicians or other professionals book the first available appointment for their patients. A referral note is written in the common file, and a detailed evaluation in the medical notes. When relevant, a case discussion follows over the phone. Ideally, an appointment for long-term medical follow-up is made at the time of referral to the program to avoid additional delay.

Key Findings: The need for this service has been confirmed by the high number of referrals.

It has proven to be an ideal setting to teach interviewing techniques “live in action” and to provide a role model for Family Medicine residents by way of direct supervision.

Lessons Learned: This type of clinical activity is energy- and time-consuming. The high number of missed appointments (despite the fact that appointments are confirmed the day before) is frustrating, since there is a waiting list. The program has not yet been able to meet its initial goal of a maximum two-week wait for evaluation. As well, it is difficult to get a “team feeling”. The three physicians work independently and their schedules do not overlap, so there is no opportunity for informal case discussion and consultation.

Implication: It is hoped that this service will be a starting point for the creation of a mental health team with other professionals in the CLSC.

Contact: Dr. Sophie Galarneau, CLSC des Faubourgs
2260 Parthenais, Montreal QC H2K 3T5
Tel: (514) 527-4929 ext. 340 e-mail: sogalarneau@hotmail.com

Montreal Shared Care

Sponsoring Organizations:	Montreal General Hospital, Department of Psychiatry CLSC-Metro
Starting Date:	1996
Rationale:	The project began in response to the shift to community-based mental health care in Quebec.
Goal:	To provide a structure in which the CLSC could provide ongoing care to those with severe mental illness.
Description:	Prior to the inception of this project, the CLSC provided short-term follow-up of psychiatric patients, and did not really work with individuals with severe mental illness. With the closure of 40% of hospital beds at Montreal General Hospital, an ACT team was set up and it was arranged that staff from the Hospital Department of Psychiatry would go to the CLSC to help develop a mental health team. The CLSC received approximately $60,000 in extra funding and was able to hire a psychiatric nurse. The team also benefited from staff transfers, specifically the addition of three nurses, an occupational therapist, a psychologist and a family physician, all part-time. Currently, a psychiatrist, a senior psychiatry resident and three junior psychiatry residents attend the CLSC for 1/2 day per week. The psychiatrist primarily does one-time consultations, but also provides some ongoing care until the family physician is able to take over. The psychiatrist also provides a liaison between the CLSC and the Hospital Emergency Department to ensure proper reception of the CLSC patients who are brought there by members of the CLSC mental health team.
Key Findings:	Waiting time in the Emergency Department has been dramatically reduced for patients and for the CLSC mental health team members accompanying them.
Difficulty Encountered:	The greatest difficulty has been retaining a psychiatrist on the team.
Contact:	Dr. Warren Steiner, Director, Outpatient and Community Psychiatry Montreal General Hospital , McGill University Health Centre 1650, avenue Cedar, Montreal, QC H3G 1A4 Tel: (514) 934-8010 Fax: (514) 934-8391 e-mail: mcws@musica.mcgill.ca

West Niagara Mental Health - Primary Care Initiative

Sponsoring Organization: West Niagara Mental Health Team/Beamsville Family Practice Unit

Funding: Ministry of Health and Long-Term Care sessional fee funds flowed through the Mental Health Team.

Starting Date: March 29, 2001

Rationale: The community served is a rural area, proximal to the urban centre of Hamilton, Ontario. There is a significant shortage of family physicians and virtually no child and adolescent mental health services in this community. In light of the demand for service and a relative lack of resources, it was felt that one way of optimizing mental health care for individuals who were less severely ill and/or who would not be willing to visit a "mental health service" for reasons of stigma (which is significant in a rural setting, particularly one where anonymity is complicated by proximity and a relative lack of privacy) was through the provision of mental health services in the family physician's office. It was also expected that such a program would provide an opportunity for joint assessments by family physician and psychiatrist and constructive dialogue about treatment options.

Goals: To provide mental health consultation on-site in primary care, initially at one site and subsequently at other sites;

To provide an opportunity for informal education to family physicians concerning patient problems identified for assessment;

To enhance the personal relationship between the family physicians and the mental health team;

To improve access to mental health services for patients who, for reasons of stigma, may be reluctant to be assessed in either the community or a mental health clinic.

Description: The West Niagara Mental Health Team is an Ontario Ministry of Health and Long-Term Care-funded program which provides a range of services to residents of a rural area proximal to an urban centre in southern Ontario. Services include intensive, community-based case management for individuals suffering from serious mental illness, and shorter-term moderate case management for individuals with less severe but still distressing and/or disabling mental health problems. Problems arise that are common to rural settings, including transportation and a lack of ancillary support services such as vocational support, subsidized housing and general counselling.

Activities to date include planning meetings, half-day visits to the Beamsville Family Practice Clinic, and patient assessments, sometimes involving the family physician. Meetings have been held with family physicians, family practice residents and clinical clerks, providing an opportunity to review topics including adult attention deficit disorder, obsessive-compulsive disorder, social phobia, borderline personality disorder, dysthymia and major depression, psychotherapy including IPT and CBT and the pharmacotherapy of depression in the context of co-morbidity.

Key Findings: To date, physicians report that the informal case-based discussion which follows actual patient assessments has been highly instructive and significantly valued. The learners, including residents and clerks, are similarly pleased.

Implications: The kind of informal contact encouraged by this program is expected to improve the communication between the referring physicians and the mental health team and also allow for ongoing informal continuing medical education. It is hoped that this will extend not only to residents in family practice but also to allied health professionals such as nursing staff.|

Contact: Dr. Steven Webb, West Niagara Mental Health Team, 167A Main Street East
Grimsby, Ontario L3M 1P2
Tel: (905) 309-3336 Fax: (905) 309-4446 e-mail: mjmspw@netscape.net

Consultation to Community Health Centres

Sponsoring Organization: Each participating health centre uses funding from its internal budget.

Starting Dates: Carlington Community and Health Services - March 10, 1993
Pinecrest-Queensway Community Health Centre - September 15, 1994
Centretown Community Health Centre - December 1, 1997
South-East Ottawa Community Health Centre - April 18, 2000

Rationale: The program developed to address the needs of clients with multiple problems who were using many health centre services which were sub-optimally coordinated; to address the fragmentation and divisiveness between disciplines especially medical (primary health care) and non-medical; to provide clinical guidance and skill-building in managing a sizeable caseload of clients suffering from psychiatric disorders; and to obtain clinical input into community initiatives or prevention programs (secondary or tertiary) targeting specific high-risk populations.

Goals: To provide client- and consultee-focused consultation to frontline workers in primary care, counselling, prevention and community development programs;

To provide direction and education concerning the management of clients with mental health difficulties and complex psychosocial problems, as this clientele forms a large portion of the population served by the community health centres;

To facilitate and improve shared care across disciplines and programs within the centre;

To increase cohesion and consistency of practice and implementation of values outlined in the centres' mission;

To initiate and facilitate the process of systemic planning as programs are altered to meet the community's needs.

Description: The psychiatrist visits each centre every 2-4 weeks and holds regular 90-minute meetings with representatives of all service providers within each centre. Direct consultations to clients/patients are not provided. Telephone consultation is available between meetings, although this is rarely utilized. There have also been occasional longer pre-arranged education sessions.

Key Findings: The knowledge and confidence of frontline workers dealing with mental health clients with multiple psychiatric and social problems have increased. Assessment and treatment planning and re-evaluation of clinical outcomes have become more systematically implemented in day-to-day practice. There has been increasing shared consultation between clinicians and between teams. There has been increased consistency of approaches to challenging clients and situations.

Some centres have reported an increased coordination of services and an increased ability to navigate the social and mental health service systems. There is an increased ability to recognize the skills and operationalize the interventions that workers have planned. The process has helped the primary care team to take a broader perspective and a more holistic approach toward certain patient populations.

The community health centres involved for the longest in the project report that there has been an increased ability to share ideas and articulate philosophical differences, yet maintain an ability to work in a coordinated and integrated fashion when dealing with individual situations. They have also reported an increased ability to plan systemic interventions and community development strategies. Most clinicians report an increased ability to critically appraise and observe their work and to challenge each other, with a more cohesive and dynamic team approach and an increased ability to discuss their work with each other.

Lessons Learned: This form of consultation facilitates an integrated approach which dramatically increases the ability of community health centres to manage complex individual and family problems. It also helps staff morale, as they derive an increased sense that their work is meaningful and that they are valued, despite working in very difficult circumstances.

Difficulties Encountered: The biggest challenge has been to combine the medical and non-medical teams. In one of the health centres, the primary health care team split off from the group. In another, the doctors and the nurse practitioners have been somewhat frustrated by the lack of direct consultation to patients. In some centres, this has been addressed by very occasional consultation. One centre has chosen to hire someone who does more direct consultation. Telephone availability between consultations on specific clinical cases has also helped clinicians feel more personally clinically supported. Difficulties have also been encountered in convincing certain teams (often medical) that the time investment required is worthwhile, when they feel very pressed by clinical demands. This is being addressed by sustained endorsement and support from management.

Contact: Dr. Chantal Whelan, Carlington Assertive Community Treatment Team
c/o Carlington Community and Health Services
900 Merrivale Road , Ottawa, ON K1Z 5Z8
Tel: (613) 722-9731 ext. 264 Fax: (613) 722-8244
e-mail: cwhelan@carlington.ochc.org

Northeast Community Health Centre, Mental Health Shared Care

Funding: Capital Health Authority
Alberta Mental Health Board

Resources: At present, this service has access to a psychiatrist one day per week. There are three full-time mental health staff, two registered nurses and one BSW. The staff has access to many other resources, including an addictions counsellor and a registered dietitian.

Starting Date: January 1999

Goals: To integrate mental health services with the other services offered at the Northeast Community Health Centre;

To support the role of primary health care providers in delivering mental health care;

To extend the integration of services and supportive functions to other primary care providers in the community, including family physicians.

Description: The model of integrated shared care is a fundamental premise for the overall operation of the Northeast Community Health Centre. The Centre opened its doors in January 1999, and much of the first 18 months to two years focused on developing the model internally. More recently, the four professionals given responsibility for developing shared care with community partners have begun working on a framework for service delivery and evaluation. An initial step has been to organize monthly case rounds with family physicians internal to the NECHC as well as those in the community.

Contacts: Linda Cargill, Northeast Community Health Centre, 14007 - 50th Street, Edmonton, AB T5A 5E4
Tel: (780) 472-5114 or (780) 460-6267 e-mail: lcargill@cha.ab.ca

Jody Kellington Tel: (780) 472-5028 e-mail: jkelling@cha.ab.ca

Shared Care Pilot Project

Sponsoring Organization:	Simon Fraser Health Region, British Columbia
Starting Date:	October 1999 (the project has continued past its initial completion time of six months)
Rationale:	There was limited accessibility to mental health services in the region due to a restricted mandate for services and limited psychiatric time. Communication between mental health services and family practitioners was poor.
Goals:	To enhance the range of mental health services available to the patients of participating clinics; To increase the skills and comfort of family physicians in identifying and managing mental health problems; To enhance the position of each family practice clinic in the mental health continuum of care by strengthening links with local mental health services.
Description:	The project has arranged for 1/2 day of mental health service per week in each practice. Psychiatry consultations are available every second or third week. In addition, the region supported staff on a tour of the Hamilton-Wentworth program in January 2000. A half-day conference was organized to educate staff in the region in the concept of shared care. When a crucial shortage of psychiatric staff occurred, there was a unique arrangement with the psychiatric unit to have psychiatrists share management of patients with family physicians.
Key Findings:	To date, there have been 129 referrals seen for a total of 561 visits. The most common reason for referral was depression (80 referrals), followed by bipolar affective disorder (29) and psychosis (9). Visit satisfaction questionnaires were collected and scores indicate an 84% overall satisfaction rating by the patients.
Lessons Learned:	The project has shown that this service is needed and in one of the practices, the half-day could easily be increased to a full day to allow for completion of the work being done there.
Difficulties Encountered:	The counsellors have been challenged at times by not knowing the resources available to them. As well, there had been some resistance to the project by existing mental health care providers who were concerned about duplication of services, although that has improved, and there is now greater acceptance and encouragement from those initially opposed to the project. Interest in the project by other health regions in the province and strong support from management have been very helpful. Educational sessions in the region and networking with other resources have also helped break down barriers and given staff the opportunity to learn more about available resources. There have been occasional problems with scheduling of office space and access to family physicians while on site. There has been little opportunity for evaluation of the project because of limited staff and time to complete this task.
Implications:	With this model of service, better accessibility to mental health services, improved communication and working relationships between family practitioners and mental health service providers, and improvement in family practitioners' skills in dealing with mental health problems are expected.
Contact:	Ms. Jane Senay , Simon Fraser Health Region, Mental Health Services, Central Team 3405 Willingdon Avenue, Burnaby, BC V5G 3H4 Tel: (604) 453-1942 e-mail: jane_senay@sfhr.hnet.bc.ca

Primary Care Community Outreach Program

Sponsoring Organizations: Department of Psychiatry, North York General Hospital
Department of Family Medicine, North York General Hospital

Starting Date: July 1, 1996

Rationale: This program was initiated due to the lack of adequate outpatient consultation to Family Medicine by the Department of Psychiatry at North York General Hospital.

Goals: To better meet the clinical needs of patients in the North York General Hospital community;

To provide better access to mental health care services for patients in the primary care physician's office;

To educate family physicians in order to improve their delivery of mental health care;

To provide better quality clinical consultation involving not only a written consultation note but discourse and dialogue between the consultant and consultee.

Description: Contextually-based educational and clinical consultations are provided by psychiatrists in the offices of participating family physicians. The service is available to all the family physicians on staff at North York General Hospital (approximately 450). 20 to 30 family physicians regularly make use of the Outreach Consultation Service, which is felt to be a fairly high number as only a portion of the family physicians use the Outpatient Clinic as their psychiatric referral source. Many family physicians have other outpatient community psychiatrists to whom they refer.

Key Findings: Findings are anecdotal, however family physicians appear quite sophisticated in many of their mental health interventions. A great deal of patient-related information can be obtained by the participating psychiatrist, which improves the quality of the consultation with respect to the patient's diagnosis and appropriate interventions. Specific consultation skills, in addition to general clinical skills, are required by participating psychiatrists. The project continues to be highly regarded by the family physicians who make use of it.

Patients seem to appreciate the visits being in their family physician's office, where they feel comfortable. Approximately one-third of the patients seen in the outpatient setting were subsequently connected to follow-up in the hospital or to one of the hospital's mental health treatment programs.

Lessons Learned: The use of psychiatrists in a shared care approach in family physicians' offices is highly valued by family physicians and their patients. The richness and quality of the consultation seems to be satisfying for both the consultant and consultee. The opportunity for dialogue between the psychiatrist and family physician sets the shared care method of service delivery apart from the traditional split care consultation method.

Difficulties Encountered: The main difficulty has been funding for the psychiatrists providing the outpatient consultations. Some sessional funds have been provided by the Chief of Psychiatry, who has been very supportive and encouraging of the program.

Travel to the various outpatient offices can be complicated. Missed appointments can be problematic when there are only two or three patients to see. A solution to some of these problems was to book three consultations in one afternoon in the same doctor's office or the same medical building to use the psychiatrist's time more efficiently.

Implications: This program suggests that an outreach consultation to primary care can be an effective method of clinical service delivery for psychiatry in a primary care setting. More formalized and stable funding and expanded manpower resources to reach a wider range of physicians would be beneficial to the program.

Contact: Dr. Thomas Ungar, Department of Psychiatry, North York General Hospital
4001 Leslie Street, 8th Floor, North York, ON M2K 1E1
Tel: (416) 756-6655 Fax: (416) 756-6671 e-mail: tungar@nygh.on.ca

Davenport Perth Community Health Centre Shared Mental Health Care

Sponsoring Organization: The program is sponsored by the Toronto Urban Health Alliance (TUHA), a coalition of the University Health Network and five community health centres in downtown Toronto.

Resources: One psychiatrist (3 hours every two weeks) and one mental health clinician (3 hours per week) provide services at a clinic which employs 2.4 FTE family physicians, 2 FTE nurse practitioners, one senior nurse and one social worker.

Starting Date: 1996

Rationale: The program developed to provide language-specific (Portuguese and Spanish) access to psychiatric consultations on-site, as well as access to Spanish-speaking clinical support services, including a social worker and clinical psychologist.

Goals: To provide culture- and language-specific access to on-site psychiatric consultations;

To provide access to specialists and counselling services for people without health cards;

To improve primary care providers' capacity to manage acute mental health conditions at a primary care level;

To help avoid re-hospitalization;

To provide access to in-service training specific to the Health Centre's client population;

To improve the case management of complex mental health clients.

Description: Services provided include direct consultation for diagnosis and treatment, indirect consultation, didactic teaching sessions for providers, psychotherapy and counselling, language-specific mental health care, in-patient psychiatric care, emergency consultation and community health education. Cultural interpretation is available as necessary.

The Centre assesses the number of referrals, reasons for referral, impact on prescribing behaviours and patient satisfaction. From January to December 2000, 52 clients (individual or family) were assessed and advice given to the primary care provider. Direct case discussion with a physician and/or nurse practitioner or social worker was provided for 11 clients, indirect case discussion for 7. From January to May 2001, the figures for assessment, direct case discussion and indirect case discussion were 31, 4 and 1 respectively. The main reasons for referral are a request for assessment or re-assessment, medication management, and diagnosis confirmation.

Lessons Learned: This model of care improves access and collaboration and enhances continuity of care. It may reduce the number of patients who fail to keep their appointments. Overcoming language barriers is a key component in the provision of effective mental health care. The psychiatrist became involved in advocacy.

Difficulties Encountered: In the early stages, there was a rapid rate of turnover in personnel from the Hospital attached to the Centre. This problem has settled down, although not because of any systemic changes. Consultants enjoy their role and the collaborative arrangement is now working quite well. Other difficulties include the underutilization of the clinical psychologist and a high rate of “no shows”.

Implication: This model of care provides a timely response to urgent needs, especially for those without health cards.

Contact: Dr. Rosana Pellizzari, Davenport Perth Community Health Centre,
1900 Davenport Road, Toronto, ON M6N 1B7
Tel: (416) 658-6812 Fax: (416) 658-4611

Psychiatric Consultation-Liaison in the Community (General Practice) Clinic of the Royal Victoria Hospital, Montreal

Sponsoring Organization: Royal Victoria Hospital, Psychiatric Consultation-Liaison Service

Funding: Combination of fee-for-service and sessional fees

Starting Date: 1972

Goals: To lessen the load on psychiatric outpatient clinics;

To treat in a medical setting patients unlikely to accept being seen in a psychiatric facility;

To facilitate the optimal physician-psychiatrist collaboration with possibility of face-to-face contact;

To follow certain long-term somatizing patients with a view to reducing their consumption of medical resources;

To serve as a teaching resource for residents and medical students.

Description: Activities have varied over the years. Initially, it was hoped that on-the-spot consultation could be provided, and staff psychiatrists were therefore assigned to cover the full working day, five days a week. However, the demand for consultation was unpredictable, and consultants were often underutilized. In addition, funding for sessional fees was progressively decreased, especially in the 1980s. The result was a gradual shift toward fewer hours of consultant presence and a scheduling of appointments at a later date. At this time, the psychiatric presence is about 16 hours per week.

Key Findings: The project was not studied systematically, but services are used regularly and there is, at times, a waiting list of up to two months for consultations, depending on urgency. General practitioners in the clinic use the service more than specialists in other clinics, to whom consultation is also available. This is thought to be due to the fact that the consultant's office is located in the Community Clinic area, that is, the consultant is visible. Many patients are seen who otherwise would be referred to general psychiatric clinics. Its use as a teaching resource has been sporadic, due to a variety of factors, including scheduling problems in terms of students' and residents' time. Where there has been some exposure, the feedback is generally excellent, particularly when a resident has the opportunity to follow a patient for several weeks.

Lessons Learned: Full-time availability of a psychiatric consultant would be ideal, however in the now-permanent situation of limited resources, compromises have had to be made. Thus, the liaison portion of the program is more limited, but certainly not eliminated.

The activity can be very rewarding for psychiatrists who enjoy the challenges of following somatizing patients; the turnover of consultants has been very low.

Difficulty Encountered: Logistical problems in terms of training schedules and priorities make it difficult at times to provide trainees with adequate exposure to this potentially rich resource.

Contact: Dr. Annette Granich, Chief, Consultation-Liaison Service
Allan Memorial Institute and Royal Victoria Hospital
1025 Pine Avenue West, Montreal, QC H3A 1A1
Tel: (514) 842-1231 ext. 5502 Fax: (514) 843-2858

Winnipeg Shared Care

Sponsoring Organization: McDermot Group of Psychiatrists Inc. / Department of Psychiatry

Funding: Winnipeg Regional Health Authority

Starting Dates: Health Action Center - 1995
Klinic - 1998
Nine Circles Community Health Centre - 2000
Centre de Santé - 2001

Goal: Consultation to primary care physicians and case conferences with non-medical therapists.

Description: This program currently operates at four sites in Winnipeg; each is distinct.

The Health Action Center is an inner city community clinic staffed by 6 - 8 family physicians, social workers, nurses, dietitians and outreach workers. A psychiatrist provides consultations to the doctors for three hours bi-weekly. On the mornings when the psychiatrist visits, two new consults are seen and one follow-up appointment is scheduled. Patients are seen alone by the psychiatrist. Consultations are only taken from the family physicians on site. Teaching and case discussion are provided to the family physicians by the psychiatrist on an informal basis, often during patient no-shows. A formal written consult with psychiatric findings, diagnosis and suggestions for treatment is left on the chart. On some occasions, especially if the case is unusual or complex, the consultation is discussed with the family physician. Approximately half of all patients are followed by the psychiatrist for a short period of time.

Klinic is a primary care clinic established in downtown Winnipeg more than thirty years ago. There are five doctors, four nurses and one social worker, three medical assistants and one health educator on staff. In 1998, the CEO of this clinic approached the Department of Psychiatry regarding the possibility of setting up a satellite clinic. The psychiatrist who attends provides consultation to the family physicians on a fee-for-service basis, and consultation teaching and case conferences to the non-medical therapists on a sessional basis.

Nine Circles Community Health Centre has been established for over 14 years. It provides care to a core area population, many of whom are aboriginal. A significant number of patients attending this clinic suffer from substance abuse and HIV-related problems. Two physicians, three nurses and two mental health counsellors provide services to these patients. Historically, very few of the patients attending this clinic have been seen by psychiatry in consultation in the ambulatory care programs of the teaching hospitals. Recognizing that this population had mental health difficulties, the CEO of Village Clinic approached the University of Manitoba Department of Psychiatry in the fall of 2000 about setting up a “satellite” clinic for these patients. The psychiatrist visits this primary care clinic for two-and-a-half hours twice a month and provides consultation both to primary care physicians and to non-medical therapists. He also provides educational seminars at intervals and participates in case conferences on complex or difficult cases.

Centre de Santé St. Boniface Health Centre is a community health centre serving the French-speaking residents of St. Boniface and Winnipeg. Clients can gain access to a wide range of medical, preventative and educational health care services in French or English. The centre has three full-time family physicians, four to five nurse practitioners, a full-time dietitian / nutritionist, a social worker and an experienced psychiatric nurse on staff. A consulting psychiatrist from the Department of Psychiatry visits the Centre de Santé for one half day every week. The psychiatrist will see individuals referred by a Centre physician, social worker or psychiatric nurse.

The Centre family physician will usually discuss the specific reasons for the consultation with the psychiatrist beforehand, and may sit in with their patient during the consultation. Following the consultation, the psychiatrist will discuss with the family physician the proposed management plan, which may include services of other mental health care providers. The social worker and psychiatric nurse also receive requests for services from physicians working outside of Centre de Santé whose patients are French-speaking, or reside in the St. Boniface area. The individual's (non-Centre) family physician initiates a formal referral to the psychiatrist. Prior to the consultation, the counsellor will meet with the psychiatrist to discuss the specific reasons for the consultation and will usually sit in during the consultation process. The recommendations are discussed with the patient and the counsellor, who will also receive a copy of the consultation report sent to the patient's family physician. Unfortunately, as there is no face-to-face contact between the referring physician and the psychiatrist, there is no discussion about the case and the referring physician may or may not choose to follow the recommendations. Patients may be seen for a follow-up if deemed necessary by the psychiatrist or requested by the health care provider. The family physicians, counsellors and psychiatrist spend a significant amount of time discussing cases which may or may not have been previously seen. The psychiatrist also provides general and specific education about the treatment of a variety of psychiatric conditions to care providers as the need arises. The nurse clinicians, dietitian and office staff have also approached the psychiatrist for advice on managing specific clients or for information about a number of psychiatric conditions.

Beginning in July 2002, residents in psychiatry will be attending these satellite clinics as part of their community psychiatry experience.

Key Findings:

To date, patient and provider evaluations have been very positive. There has been a significant improvement of communication between family medicine and psychiatry.

Lessons Learned:

One of the lessons we have learned is that the model of service provided by psychiatry must be tailored to the unique needs of the practice of the primary care clinic. Primary care clinics requesting this service have been creative in securing funding for the sessional fees.

Implications:

Expansion of the program to other health access centres is planned. In addition, the Winnipeg Regional Health Authority is recruiting a psychiatrist to be the director of community psychiatry. It is expected that s/he will be very involved in developing further models of shared care in Winnipeg.

Contacts:

Dr. S. Barakat, Tel: (204) 787-7056 e-mail: sbarakat@hsc.mb.ca
Dr. P. Wightman, Tel: (204) 787-7098 e-mail: pwightman@hsc.mb.ca

Shared Mental Health Care

Sponsoring Organization: Nova Scotia Capital District Health Authority, Primary Community Mental Health Services

Funding: The program receives ongoing funding through the Capital District Health Authority.

Resources: The program has 0.3 full-time equivalent psychiatrists (filled by three different psychiatrists) and 4.0 full-time equivalent mental health worker positions (filled by four different mental health workers). The mental health workers are predominantly registered nurses or MSWs.

Starting Date: May 1998

Goal: To improve the mental health of people in the community by implementing an integrated service model in which mental health care is shared between mental health and primary care providers.

Specific objectives are to improve:

- access to appropriate mental health services for people in the community;
- mental health outcomes of people in the community;
- knowledge base of care providers regarding detection and management of mental health disorders;
- collaborative/consultative relationships between primary care and mental health providers.

Description: Each primary care centre has a mental health worker who is an integral part of the primary care team. The mental health worker will see or discuss any patient, regardless of age, deemed by primary care or agency staff to require further mental heath assessment and/or support. Interventions are generally short-term with an emphasis on providing access to appropriate community supports in order to ensure continuing accessibility and short waiting times for new assessments. Workers provide information to all staff about existing resources and psychoeducational strategies that can be incorporated into an effective treatment strategy for patients. Group sessions are offered to patients on a regular basis.

A consulting psychiatrist visits each centre for one half-day per week and is available in times of crisis, to provide consultations and for case discussions. Consulting psychiatrists also take part in educational activities (informal and formal) and provide backup support for the mental health workers.

Primary care staff members maintain pivotal roles in patient care, providing ongoing treatment to patients along with consultation and support to mental health and agency staff.

Agency staff members support “shared” clients in a variety of settings, often serving as conduits for communication and treatment, as well as helping to more comprehensively address psychosocial issues.

The program also offers Family Medicine and Psychiatry residents a chance to develop skills relevant to future practice and to see first-hand the benefits of collaboration between primary care and mental health services. Two of the current settings are teaching practices for the Dalhousie Department of Family Medicine, which has collaborated in the development of the service.

Psychiatry residents have elective attachments to program sites and one site now forms part of the Psychiatry Chronic Care rotation. Specific objectives relevant to this style of practice have been established in conjunction with other shared care

initiatives across Canada. Seminars pertinent to shared care practice have been ongoing for several years.

Dalhousie University is actively promoting the development of undergraduate "Blended Rotations" which address specifically those elements of collaboration and communication as demonstrated in this model. Frequent Clinical Clerk attachments at program sites have received consistently positive evaluations from students. In addition, students from the Dalhousie School of Nursing have used program sites for clinical rotations.

Key Findings:

The program receives approximately 700 referrals per year, of whom 87% are seen by the mental health worker and 28% are seen by the psychiatrist. The majority of individuals referred are female and the mean age ranges from 30-40 years. The most common presenting problems of those referred to the mental health workers are mood disorders, adjustment disorder and family dysfunction.

The median waiting time for individuals to see a mental health professional has been reduced from 5-6 weeks to 1-2 weeks. Sites report significantly more referrals by primary care providers for mental health consultations and better and more appropriate access for patients to specialized services within institutions and the community.

Outcome measurement using the DUKE has demonstrated statistically significant improvements in general and mental health scores. Consumer satisfaction with the model, as measured by the Visit Satisfaction Questionnaire (VSQ), has consistently been over 86%. Primary care providers (family physicians, nurses, social workers, and front-line agency/community workers), mental health workers and psychiatrists report a high degree of satisfaction with the model. They also report that the model has led to increased knowledge and confidence in the diagnosis and treatment of individuals with mental health problems and their families and that improvement in the communication patterns between primary care and mental health care providers has positively influenced the follow-up and ongoing treatment of patients.

Development of supportive relationships with agency staff has already led to significant initiatives. These include collaborating in the development of a proposal for assessing the mental health needs of homeless persons in Halifax which recently received a Department of Psychiatry community research grant.

Implications:

The integration of mental health care within primary care settings improves access to mental health services and enriches the quality and range of services offered. The shared care model's outreach component is of particular benefit to individuals with mental health problems that currently go undetected. These include the homeless or members of other marginalized groups whose life circumstance diminishes their ability to obtain adequate medical care. The model improves provider satisfaction and increases providers' skill and comfort in managing the mental health problems of their patients, which can lead not only to better care of patients but also healthier providers. The high level of patient satisfaction means they are more likely to return to their provider and remain in treatment.

Contact:

Dr. Karen Johl, Program Director, Department of Psychiatry
3rd floor, Abbie J Lane Building, QEII HSC, Halifax, N.S. B3H 2E2
Tel: (902) 473-2931 Fax: (902) 473-2506 e-mail: Karen.Johl@cdha.nshealth.ca

Shared Mental Health Care in a Primary Care Practice

Sponsoring Organizations: Health Transition Fund
Alberta Medical Association

Starting Date: November 1998

Rationale: The project was driven by the need of family physicians and patients to have more immediate access to psychiatric expertise and to improve communication and collaboration between family physicians and mental health professionals.

Goals: To expand the capacity of the family practitioner to recognize and treat mental health issues in patient care;

To deliver mental health services in physicians' offices in the form of consultation, brief therapy and education, leaving primary mental health care responsibility to the family practitioner, rather than referring patients elsewhere;

To ensure that patients not appropriate for office-based practice are referred to the appropriate secondary or tertiary location (for example, the hospital).

Description: At implementation, the project had contracted with 24 family physicians, two mental health clinicians and three consulting psychiatrists. Two additional clinicians were hired in May 1999. Each clinician was attached to family practices (roughly six physicians per clinician). They visited each family practitioner on a weekly basis for consultation regarding the treatment/ management of patients experiencing primary mental health problems or whose health was compromised by psychological or psychosocial problems. Consultant psychiatrists were available to the family physician by telephone or personal visit. Educational sessions were held to address mental health-related topics chosen by family physicians. A Shared Mental Health Care Steering Committee, comprised of senior administrators from Family Medicine, Mental Health, and Psychiatry oversaw the project and met on a monthly basis.

A quantitative and qualitative evaluation of the first twelve months of operation was completed in May 2000, based on a conventional participant-perspective model.

Key Findings: Participation in the project contributed to increased knowledge and confidence among family physicians to identify and manage mental health issues in their practice, more appropriate referrals to outside agencies, improved diagnostic capabilities, and more time spent counselling patients.

Mental health clinicians indicated that physicians shifted from being solely "prescribers"and"fixers" to being enablers and facilitators, and seemed to prescribe psychotropic medication more appropriately.

Over 60% of the patients were able to describe their symptom/illness from a biopsychosocial perspective. Depression and anxiety were among the most common presenting problems. Patients were satisfied with services received, and commented on the convenience, accessibility, and absence of stigma compared with being treated in a "mental health" office. Close to 70% of the patients interviewed felt that they had shown some improvement. Highest level of post-treatment functioning on the SF-36 was the anxiety/panic group; poorest functioning was the chronic pain/fibromyalgia/migraine group.

No significant relationships between the individual patient satisfaction items, the patient enablement items, and patient-perceived health status suggest that high levels of patient satisfaction are not predictive of high levels of patient-perceived health status.

Lessons Learned: The project demonstrated the successful integration of physicians, mental health clinicians, and psychiatrists in a primary care setting. There was a definite need for

active therapy in the physicians' practices. A decrease in visits to hospital Emergency Departments was also recorded among the shared care patient population.

Implications:

It would be advantageous to formalize the mix of professionals through training programs including opportunities for both medical and non-medical health professionals.

The high prevalence of depression as a presenting problem in the family physician's office has implications for the definition of "medically necessary services" (e.g., mental health counselling).

Negotiations are currently underway with Alberta Health and Wellness and the Alberta Medical Association, with the aim of ensuring that family physicians' consultation time with mental health professionals that is, at present, not allowed as a billable procedure, be included in the physician fee schedule.

Contact:

Mr. Jim Merchant, Director
Adult Mental Health & Psychiatric Primary/Community Program
Alberta Mental Health Board
#206, 301 - 14th Street, NW, Calgary, Alberta T2N 2A1
Tel: (403) 297- 4986 e-mail: jmerchant@amhb.ab.ca

Hamilton HSO Mental Health & Nutrition Program

Sponsoring Organizations: Ontario Ministry of Health and Long-Term Care
St. Joseph's Healthcare, Hamilton

Funding: The Program receives ongoing funding through the Ontario Ministry of Health and Long-Term Care Alternate Payments Branch.

Resources: The Program has 2.2 full-time equivalent psychiatrists (filled by 15 different psychiatrists) and 24 full-time equivalent counselling positions (filled by 40 different counsellors). The counsellors are predominantly MSWs, registered nurses, or BSWs. The Program also administers a Nutrition Program that integrates 7 registered dietitians into the offices of the same family physicians. A central team comprised of a part-time director, coordinator, research / evaluation coordinator and support staff coordinate the program.

Starting Date: May 1994

Goals: To integrate mental health services into the offices of 87 family physicians in 51 practices across Hamilton;

To increase access to mental health care for primary care patients;

To strengthen links between mental health and primary care services;

To support the role of primary care providers in delivering mental health care.

Description: Each practice has a counsellor who is integrated as part of the primary care team. The amount of time depends on practice size, but is approximately one full-time equivalent for every 8,000 patients. A consulting psychiatrist visits each practice every 1-4 weeks depending on practice size. The ratio is approximately 1/2 day per month per family physician.

Counsellors and psychiatrists will see any case referred by the family physician, including children, adolescents and the elderly, with priority given to the seriously mentally ill. The emphasis is on short-term care, although in each practice a number of individuals are seen on an ongoing basis. Psychiatrists will see individuals in consultation, but approximately half of these individuals will have a follow-up visit. The psychiatrist will meet with the family physician to discuss the specific reasons for the consultation before the person is seen and to go over the proposed management plan before the patient leaves.

The counsellor and psychiatrist spend a significant amount of time discussing cases with the family physician that may not need to be seen or have already been seen, but do not need a follow-up visit. Psychiatrists will also organize educational sessions for family physicians. These may be formal meetings with a group of physicians, but are usually informal case-based discussions ranging from 1-5 minutes in duration. The psychiatrist is also available to back up the counsellor and the family physician by phone in between visits.

The program has organised a series of groups, often based around groupings of practices that are in the same area. Groups have included stress management for women, men's self-esteem, depression education, couples communication, interpersonal skills and parenting programs.

The central program also organises educational events for counsellors, psychiatrists and family physicians, provides educational materials to practices for providers and patients, and circulates relevant references or items of interest, such as changes in mental health services, to practices. Child psychiatrists and geriatric psychiatrists are also available to staff of participating practices for telephone advice and periodic meetings to discuss cases.

Key Findings:

The Program receives approximately 4,200 referrals per year, of whom 88% are seen by the counsellor and 25% by the psychiatrist. 13% are under the age of 18 and 8% are over the age of 65.

The main presenting problems of individuals referred to the counsellors are depression, anxiety and family problems.

On average, each family physician in the Program refers 11 times as many individuals for psychiatric assessment compared to before the Program began. At the same time, referrals by these physicians to outpatient services are down by 70%, while inpatient admissions are down by 10% with a slightly shorter length of stay for the patients of these practices.

Outcome measurements using the CES-D and GHQ have demonstrated significant improvement in over 70% of individuals being seen. Consumer satisfaction with the Program has consistently been over 90%, as have family physician, counsellor and psychiatrist satisfaction.

Implications:

Bringing mental health teams into primary care settings is an effective way of increasing accessibility to mental health care, strengthening links between mental health and primary care providers and increasing family physicians' skills and comfort in managing the mental health problems of their patients.

Contacts:

Dr. Nick Kates, 40 Forest Avenue, 2nd floor, Hamilton, ON L8N 1X1
Tel: (905) 521-6133 Fax: (905) 521-6107 e-mail: nkates@mcmaster.ca

Anne Marie Crustolo, Coordinator
Hamilton HSO Mental Health & Nutrition Program
40 Forest Avenue, Hamilton, ON L8N 1X1
Tel: (905) 521-6133 Fax: (905) 521-6107 e-mail: acrustol@mcmaster.ca

Publications:

Kates N, Craven M, Crustolo A, Nikolaou L. Integrating Mental Health Services into the Family Physician's Office: A Canadian Program. Gen Hosp Psych 1997; 19:324-332.

Kates N, Craven M, Crustolo A, Nikolaou L, Allen C, Farrar S. Sharing Care: The Psychiatrist in the Family Physician's Office. Can J Psych 1997; 42(9): 960-965.

Kates N, Crustolo A, Nikolaou L, Farrar S, Craven M. Providing Psychiatric Backup to Family Physicians by Telephone. Can J Psych 1997; 42(9):955-959.

Peterborough Regional Health Centre

Sponsoring Organization: Peterborough Regional Health Centre

Funding: Psychiatric sessional fees

Starting Date: 1994

Rationale: The program developed in response to a severe shortage of psychiatrists and difficulty providing adequate mental health care in a schedule one facility.

Goal: To provide adequate mental health services in a community with a severe shortage of psychiatrists.

Description: Family doctors have been included in the Department of Psychiatry since 1994. Currently, one doctor works in the Adult Outpatient Program, assisting in continuing quality improvement projects and planning activities. She also sees patients for psychotherapy one day each week. Three family physicians assist in the on-call schedule, working as first on-call for psychiatry and referring patients for emergency psychiatric appointments or admitting patients to the Inpatient Unit, where the family physician and psychiatrist provide shared care.

If patients have a family physician who has privileges at the hospital, treatment will be provided by that physician for the duration of the admission. A psychiatrist is usually involved in the care, on an informal shared care basis. There are currently five family physicians who are members of the Department of Psychiatry. They attend monthly Department meetings and continuing medical education events.

Key Findings: The inclusion of family physicians in the Department of Psychiatry has been of significant benefit to the Department in its dealings with other medical departments in the hospital. It has also increased the knowledge and expertise of those physicians who are interested in psychiatry and are members of the Department. It has allowed the Department of Psychiatry to develop better working relationships with the Emergency Department and the Department of Pediatrics, in particular.

Lessons Learned: The arrangement indicated that, with some upgrading of education and ongoing liaison with psychiatrists, family physicians could participate effectively in the provision of adequate mental health services.

Difficulties Encountered: Over time, a number of family doctors discontinued their involvement while the number of psychiatrists increased to an adequate number. Reasons given by the family doctors who discontinued their involvement were stress, inadequate remuneration and other professional commitments. There has been an increasing shortage of family doctors in the community. To some degree, there has been a perception within the community that family doctors could not provide the same level of care as psychiatrists. This perception has been somewhat decreased by liaison with the Emergency Department, the Department of Family Practice, and with community mental health agencies. Due to lack of money, it was not possible to effectively address the issue of remuneration.

Contact: Dr. F. G. McNestry, Chief of Psychiatry, Peterborough Regional Health Centre
One Hospital Drive, Peterborough, ON K9J 7C6
Tel: (705) 743-2121

Cranbrook Psychiatric Unit

Sponsoring Organization:	Cranbrook Regional Hospital
Funding:	Funding for the Ward Clinicians at the hospital is provided by the hospital on a sessional basis.
Starting Date:	1994
Rationale:	The project began in response to the shortage, and sometimes absence, of psychiatrists in the region.
Goal:	To provide mental health care for psychiatric in-patients.
Description:	Care of patients in the Cranbrook Psychiatric Unit is shared between family physicians and psychiatrists, with the family physician generally assuming responsibility for primary care and the psychiatrist acting as consultant. The family physician, either in consultation with a referring family physician from outside Cranbrook, or with the psychiatrist who arranges the admission, performs an initial workup, history and physical examination. The patient is then seen by the consulting psychiatrist. All the family physicians in Cranbrook have admitting privileges to the Psychiatric Unit. Three family physicians act as Ward Clinicians. Two of the Ward Clinicians also do sessional work for Community Mental Health, which involves attending a weekly triage meeting of clients who have presented to Mental Health for services. One of the Ward Clinicians is also involved in the Elderly Outreach Program, which meets once each week to discuss the intake of new patients into the Elderly Outreach Program. The Ward Clinicians are also responsible for all admissions from outside of Cranbrook.
Key Findings:	Under the supervision of the three Ward Clinicians, the Unit was maintained even at a time when the community had no psychiatrist. The liaison between the Psychiatric Unit and the Mental Health Centre has improved considerably since two of the Ward Clinicians became involved with the Community Mental Health Centre.
Contact:	Dr. Glen R. McIver, F.W. Green Medical Centre, 1629 Baker Street, Cranbrook, BC V1C 1B4 Tel: (250) 426-5281 Fax: (250) 426-5285

Visiting Psychiatrist in Primary Care

Sponsoring Organization: Lanark County Mental Health provides sessional funding.

Starting Dates: Lanark Community Health Centre - 1994
Centre Town Community Health Centre - 2000
Lanark County Mental Health - 2000

Rationale: The consulting psychiatrist was approached by a family physician who had identified a need for a consulting psychiatrist at the Centre.

Description: A consulting psychiatrist provides outreach mental health services in rural Ontario.

One day per month, she visits Lanark Community Health Centre, meeting with the clinical staff to discuss referrals and issues arising from previous assessments. She also provides direct consultation to patients, meeting afterward with the referring clinician. All follow-up care for the patients seen in consultation is provided by the family physician. The psychiatrist is available by telephone between visits. She also provides case discussion, didactic teaching sessions and presentation of topics chosen by staff.

One afternoon per week, she works collaboratively with the Homelessness Team at Centre Town Community Health Centre, providing direct consultations and assessments, as well as support and information to the referring clinicians and community workers.

Three days per week she works at two sites of Lanark County Mental Health, an agency responsible for providing mental health services to a vast rural area. Referrals for psychiatric assessment as well as those for general counselling are reviewed. Referrals and clinical issues are discussed and an in-service is presented on a topic chosen by staff. Patients are seen for an initial consultation, following which the psychiatrist speaks with the referring clinician. All subsequent care is provided by the referring family physician or Centre staff, with telephone support available from the psychiatrist. Public lectures on mental health topics of general interest are also presented by the consulting psychiatrist.

Key Findings: Informal feedback from the family physicians and Centre staff has been positive, with more formal evaluation being considered.

Contact: Dr. Mary Johnston, Lanark County Mental Health, 88 Cornelia St. W., Unit A2
Smiths Falls, ON K7A 5K9
Tel: (613) 283-2170 Fax: (613) 283-9018

Adult Outpatient Psychiatric Clinic, Mental Health Program, Sault Area Hospitals

Sponsoring Organizations: Mental Health Program, Sault Area Hospitals
McMaster University
University of Toronto Psychiatric Outreach Program

Resources: Visiting psychiatrists from two academic Health Sciences Centres, a Clinical Nurse Specialist and the Medical Director, Mental Health Program, Sault Area Hospitals. More than two dozen visiting psychiatrists have been involved with the program since its inception.

Starting Date: January 1996

Rationale: The program was devised to provide a means to divert consultations from the sole hospital-based psychiatrist, to provide more timely consultations (average waiting time had been six months for urgent consultation), and to improve and expand the relationship between psychiatry and family practice, which had been minimal. The belief was that with a radical change in the traditional consultative and transfer of care model then being used in Sault Ste. Marie, and with adequate support, family physicians could provide the majority of psychiatric care in an outpatient setting.

Goals: To provide timely psychiatric consultations to family physicians who practise in Sault Ste. Marie irrespective of their affiliations with other mental health programs or with Sault Area Hospitals;

To provide psychiatric consultations to local psychiatrists in areas of sub-specialties and tertiary care needs;

To improve the relationship between psychiatry and family medicine;

To provide support and education to family physicians to effect improved psychiatric care of patients;

To expose psychiatric residents to alternate models of psychiatric service;

To involve allied mental health professionals, specifically a Clinical Nurse Specialist (CNS), in the provision of advanced psychiatric care;

To effect a different model of psychiatric care involving close collaboration between psychiatrists, family physicians and a CNS in the provision of care;

To improve access and predictability of specialized psychiatric care to patients in a remote underserviced community in Northern Ontario;

To reduce inappropriate admissions to the Psychiatric Unit;

To effect early detection and treatment of mental illness in patients.

Description: From 1996 to 1998, with a roster of twelve visiting psychiatrists (0.4 FTE of service), 1,142 consultations were provided. On average, each visiting psychiatrist provided two days of service per visit. There were 39 planned resident visits for short-term (two-day trips) electives with the visiting psychiatrists and medium-term (one-month) electives with the Medical Director.

Key Findings: The most common diagnoses of the patients seen were mood disorders (48.2%), anxiety disorders (14.9%) and adjustment disorders (4.8%). 52.8% of the patients presented with comorbid conditions, the most common being anxiety disorders, mood disorders and substance abuse. Less than 5% of the clinic patients had to be referred to local psychiatrists for ongoing care.

From 1996 to 1998, the number of referring physicians grew to include almost 80% of all family physicians in the community. Their satisfaction level was high; a 1996 survey indicated more than 80% being very satisfied with the service. A 1998 survey indicated more than 80% of family physicians felt that their needs were "definitely" being understood and more than 70% indicated that they "definitely" learned something new or helpful.

The use of a CNS to coordinate the activities of the Clinic was highly successful and valued by both the visiting psychiatrists and referring family physicians.

Lessons Learned:

With appropriate support, family physicians were willing and able to manage severely mentally ill patients in an outpatient setting. With training and direction, a CNS could be utilized to provide an advanced level of psychiatric care, and could become a resource person for local physicians. There was an improvement in the relationship and collaboration between family physicians and psychiatrists. There was a high degree of participation by family doctors in planned continuing education events with emphasis on contextual learning and information meetings with psychiatrists. It was crucial that the Medical Director of the local hospital provided backup support to the visiting psychiatrists and CNS for emergency and urgent needs to ensure continuity of service to patients and maintenance of the integrity of the Clinic and clinical responsibilities to all key participants in the Clinic.

Difficulties Encountered:

First and foremost, there was difficulty obtaining funding for the CNS, who had to accept the uncertainty of the permanence of the funding. The benefit of the CNS had to be demonstrated through a pilot program before the funding became permanent. Furthermore, the concerns of the local union, ONA and the Ontario College of Nursing that the responsibilities of the CNS as listed in the job description were beyond the normal scope of practice of a nurse registered in Ontario had to be addressed. Legal concerns were dealt with through delegated medical acts to ensure that the CNS was protected in her clinical activities with patients. Discussions were held with the local Union to explain the purpose of the Clinic and the job description and scope of practice of the CNS, which included an explanation of her additional intense medical education and close supervision by the on-site and visiting psychiatrists. In addition, the Clinic had to be justified to the various other competing medical programs in a period of severe budget cuts. The Clinic was put forward as a priority for the Mental Health Program, and one crucial to the retention of the on-site psychiatrist.

Implication:

This shared care model of an Outpatient Clinic could be successfully implemented in a remote, underserviced community with a high level of satisfaction by all participants.

Contact:

Dr. Henry Leung, Medical Director, Mental Health Program, Sault Area Hospitals, 969 Queen Street East, Sault Ste. Marie, ON P6A 2C4
Tel: (705) 759-3434, ext. 4616 Fax: (705) 256-3494
e-mail: leungh@sah.on.ca

Clinical Nurse Specialist Perspective on Psychiatric Outpatient Clinic

Sponsoring Organization: Sault Area Hospitals

Funding: Sault Area Hospitals (global funding)
Ontario Ministry of Health and Long-Term Care - Underserviced Area Program

Resources: The program has 1 FTE Clinical Nurse Specialist, .2 FTE clerical support, and .4 FTE psychiatrists. A team of 12 visiting academic psychiatrists works in the Clinic on a rotational basis providing two days of service on each occasion. The same psychiatrist returns every 6-8 weeks. Recently .5 FTE social worker was added.

Starting Date: February 1996

Rationale: Sault Ste. Marie is underserviced with regard to psychiatrists, resulting in waiting times of more than six months for consultative care. Before the clinic opened, the majority of patients with mental health needs went to the emergency room, and were admitted to be assessed by a psychiatrist. The Outpatient Clinic was formed to provide timely consultation for patients with urgent mental health needs and to thereby alleviate overuse of inpatient beds.

Goals: To provide timely psychiatric consultation and limited follow-up to adults with urgent mental health needs;

To reduce unnecessary admissions through the Emergency Department;

To reduce workload pressures on local psychiatrists;

To provide education for family physicians.

Description: Family physicians refer patients with urgent mental health needs for consultation with the visiting academic psychiatrists. Referral forms are triaged and screened by the Clinical Nurse Specialist (CNS). Explicit inclusion and exclusion criteria are to be met. If a referral is questionable, the CNS contacts the physician for further information and clarification.

The time allotted for each consultation is 1.5 to 2 hours. After seeing the patient, the consultant contacts the referring physician by telephone to discuss his/her findings and recommendations, and to answer any questions. A detailed written report is sent to the referring physician within one week. Cases are also reviewed with the CNS.

The more complex cases, or those requiring close monitoring, are referred to the CNS for follow-up care. Care is limited to four months to ensure access. The CNS provides written progress reports to the family physician and fields telephone calls, answering any questions and offering additional support. The CNS acts as a liaison between the consultants and referring physicians. Telephone advice is offered by the CNS, although the actual adoption of recommendations remains the responsibility of the family physician. By virtue of her training and knowledge, the CNS has become a valued resource for family physicians.

Based on the results of a learning needs assessment, formal education sessions were arranged for family physicians utilizing the expertise of the visiting academic psychiatrists and the CNS.

Key Findings: From 1996 to 1998, the number of patient visits to the clinic rose from 745 to 1,486. The number of referring physicians grew from 56 to 79, representing more than 80% of family physicians in the community. A 1998 referral source satisfaction survey indicated that over 90% were satisfied to very satisfied with the service.

Preliminary studies indicate a decrease in admission rates including the closure of a 10-bed “psychiatric overflow” unit in 1998. There has been limited additional workload demand on local psychiatrists. Assessment of referrals from 1996 to the

present indicates an increased level of comfort and expertise in the use of treatment modalities, particularly in psychopharmacology. There has been an improvement in the relationship between psychiatry and family practice. Waiting time for psychiatric consultation has been reduced from six to approximately two months.

Lessons Learned: The extended shared care model including the use of a Clinical Nurse Specialist has been well received by family physicians. An allied health professional can provide additional support to the family physician by acting as a liaison between the family physician and the psychiatric consultant. This model has been particularly useful in a geographic area with a severe shortage of psychiatrists.

Difficulties Encountered: Despite the intensive training and preparation of the CNS, family physicians were initially skeptical that a nurse could serve as a resource person to them. The CNS' involvement in the educational sessions and the visiting consultants' active support helped to facilitate a positive working relationship with the referring physicians. Over time, and with repeated use of the service, credibility was established and close relationships developed.

Implications: The involvement of the CNS in an outreach model that utilizes consultant psychiatrists provides a local resource to family physicians which was previously unavailable due to the severe shortage of local psychiatrists. Coordination of services and continuity of patient care are also enhanced.

Contact: Ms. Jane Sippell, Manager, Mental Health Programs, Sault Area Hospitals,
969 Queen Street East, Sault Ste. Marie, ON P6A 2C4
Tel: (705) 759-3434, ext. 4117 Fax: (705) 256-3459 e-mail: Sippellj@sah.on.ca

Psychiatric Outreach Program, Mental Health Evaluation and Community Consultation Unit (MHECCU), Department of Psychiatry, University of British Columbia

Sponsoring Organization: Department of Psychiatry, University of British Columbia

Funding: The British Columbia Ministry of Health, Ministry Responsible for Seniors and Ministry for Children and Families provide annualized funding for the delivery of psychiatric outreach to communities in the province.

Resources: The Psychiatric Outreach Program currently has 65 consultant psychiatrists. Psychiatric residents often participate under the supervision of a psychiatrist.

Starting Date: The Psychiatric Outreach Program was developed in 1976.

Goal: To deliver psychiatric outreach services in rural and remote underserviced communities, including

- direct clinical psychiatric service to patients;
- indirect service through discussions and consultation with referring physicians or community agencies;
- education for physicians and care providers on assessing and caring for persons with possible mental disorders;
- clinical case reviews with multidisciplinary teams of care providers.

Description: The Psychiatric Outreach Program provides regular visits by psychiatrists to communities that have no resident psychiatrist or need to augment their available psychiatric care. The service includes outreach to children, youth and their families, adults and the elderly.

Initially, MHECCU works with the local regional health board or community health service society's mental health staff to arrange for adult and elderly outreach visits. Typically, the outreach psychiatrist will be based at the mental health centre during visits to the community being served. The Child and Youth Outreach Program operates similarly, with the regional Child and Youth Mental Health Office arranging visits and the psychiatrist working in the local Ministry for Children and Families Mental Health Office.

The most typical arrangement is one in which a psychiatrist visits a particular community every second month, although this varies widely. Larger communities have a roster of four or more psychiatrists who visit on a rotating basis.

Key Findings: During fiscal year 2000-2001, outreach psychiatrists made approximately 440 visits to 42 communities in the province of British Columbia. As many psychiatrists visit the same community for a number of years, a relationship develops between the community and the psychiatrist.

Lessons Learned: The provision of mental health services is often hampered by a lack of physicians trained in psychiatry and by poor access to mental health support services. A review of the Program conducted in 2001 recommended that:

(1) Expansion of the program's resources is needed to meet the demand for services in many communities;

(2) Changes should be made in the program design to make it more equitable and to encourage more local and regional involvement;

(3) The Program should be regularly monitored to track performance, review the allocation of resources and facilitate opportunities for continuous program improvement;

(4) MHECCU and the Post-Graduate Office need to work together to encourage more resident involvement;

(5) More research needs to be undertaken to assess options to improve mental health delivery to the First Nations population. Consideration should be given to increasing access to telepsychiatry and telemental health services, especially in communities with long waiting lists or infrequent visits.

Implications: Funding structures will have to change in order to move from the current model to one including training and education, and capacity-building. The use of sessions for indirect care has to be facilitated. Currently, sessions can be used only for direct patient care.

Contact: Ms. Diana Lambrou, Executive Director
Tel: (604) 822-7550 e-mail: Lambrou@interchange.ubc.ca

University of Toronto Psychiatric Outreach Program

Sponsoring Organizations: Ontario Ministry of Health and Long-Term Care
Northern Programs and Planning Branch

Other Participants: University of Toronto
Centre for Addiction and Mental Health
University of Western Ontario Extended Campus Program
University of Ottawa Francophone Outreach Program
Northern Academic Health Sciences Network (NAHSN)

Starting Date: 1994

Goals: To provide clinical service, education and support of the highest quality to communities throughout Ontario, in particular to communities that are rural, remote or are considered underserviced in terms of mental health care;

To strive toward multidisciplinary, contextually relevant, community-oriented service and education;

To situate residents in underserviced areas for core training.

Description: The Program provides clinical service and education to rural and northern communities across Ontario, and has become one of the biggest providers of psychiatric services and psychiatric resident training in rural Ontario, serving a catchment population of over 350,000. In 2000, the Program involved more than 50 consultants (providing more than 1,000 days service), as well as residents and medical students, (providing more than 400 days service) at sites including Atikokan, Campbellford, Elora, Fort Erie, Kenora, New Liskeard, North Bay, Parry Sound, Peterborough, Sault Ste. Marie, Sioux Lookout, Thunder Bay, Timmins, Uxbridge, and Wawa. The Program also provides televideo services for patient consultation and continuing medical education.

In January 2001, the Program inaugurated its first core rotation in general psychiatry at the North Bay Psychiatric Hospital. A second core rotation in geriatric psychiatry is planned for July 2001 for the North Bay site. The Program is also exploring core rotations for the Thunder Bay site.

Each community site has a coordinator, or pair of coordinators, one of whom lives in the partner community. The psychiatric consultations may be centred on the patient, the consultee, the program, the community, or may be administrative or educational. Once a year, all participants in the Program, including faculty consultants, residents, multi-disciplinary staff and community members get together to set objectives for the next year. The Program also has a number of specialty services, (including child and geriatric psychiatry services), working committees, (including Clinical Service, Faculty Education, Financial Development, and Postgraduate Education) and educational activities.

Key Findings: There are several unique aspects of work in underserviced areas, which guide the way clinical services are structured.

There are cultural differences between Native and non-Native populations. Clinicians working with Native Canadians may, for example, need to alter their normal style. They must also understand that cultural differences play a role in the delivery of treatment.

There are cultural differences between people living in rural and urban areas. For example, confidentiality and sensitivity to where information goes are much more important in small communities than in the relative anonymity of a large city.

Implications:

Due to the extreme shortage of psychiatrists and limited clinical time, the majority of mental health care is provided and will continue to be provided by non-psychiatrists. Rather than "taking over" care of patients, visiting psychiatrists should act as consultants and supports for existing practitioners. The consultant psychiatrist must help front-line professionals, particularly family physicians, to develop the skills to treat as many patients as possible without requesting consultation.

Models of treatment which emphasize brief treatment and shared care with other professionals are particularly useful for underserviced populations such as homeless or multicultural groups and under-resourced geographic areas.

Contact:

Dr. Brian Hodges, Director,University of Toronto Psychiatric Outreach Program
Centre for Addiction & Mental Health
250 College Street, 8th Floor, Toronto, ON M5T 1R8
Tel: (416) 979-4971 Fax: (416) 979-6902 e-mail: brian.hodges@utoronto.ca

McMaster University Psychiatric Outreach Program

Sponsoring Organizations: McMaster University
St. Joseph's Healthcare, Hamilton

Starting Date: James Bay - 1992; Sault Ste. Marie - 1995

Rationale: Northern communities are underserviced in psychiatry. Providing scheduled occasional psychiatric coverage was one way to alleviate the shortages.

Goals: To provide psychiatric services to rural, remote and underserviced communities;

To allow residents to experience psychiatry as it functions in a variety of rural, remote or underserviced areas.

Description: Psychiatrists from McMaster University provide fly-in psychiatric services to the James Bay and Sault Ste. Marie communities. Services include consultations to family physicians as well as working closely with community and mental health workers. Emphasis is on family physicians' education as well as treatment/ management. The Outreach program is open to psychiatric residents as an elective opportunity. There are currently six physicians involved in the program. A telepsychiatry (videoconferencing) option is available.

Lessons Learned: Recruitment of fly-in psychiatrists is one issue, retention another. Success of the program reflects ongoing input and special attention to the relationship with key personnel at the northern site. Although not the ideal situation, this project provides significant support to underserviced areas.

Difficulty Encountered: Retention of staff in the absence of resources has been difficult.

Contact: Dr. Gary Chaimowitz, Forensic Unit
St. Joseph's Healthcare, Centre for Mountain Health Services
100 West 5th Street, P.O. Box 585, Hamilton, ON L8N 3K7
Tel: (905) 522-1155 ext. 5424 Fax: (905) 381-5606
e-mail: chaimow@mcmaster.ca

Calgary Urban Project Society (CUPS) Shared Care Mental Health Program

Sponsoring Organizations: Calgary United Way
Alberta Health and Wellness, Health Innovation Fund
Alberta Medical Association

Resources: The CUPS Shared Care Health Team is comprised of a physician (1.0 FTE), nurse practitioner (0.8 FTE), registered nurse (1.0 FTE), licensed practical nurse (1.0 FTE), mental health nurse (1.0 FTE), consulting psychiatrist (0.1 FTE) and social worker (1.0 FTE).

Starting Date: June 2000

Goals: To create an integrated, multidisciplinary health care team that practises within a collaborative treatment model and shares in the provision of holistic care (i.e., body, mind, spirit) to Calgary's homeless who are mentally ill. Successful implementation of this model will:

- Improve access to mental health and primary health care services and support for Calgary's homeless mentally ill;
- Improve CUPS' ability to provide comprehensive, quality mental health care to the homeless mentally ill; and
- Increase coordination of services to the homeless mentally ill through stronger collaborative links between CUPS, the Alberta Mental Health Board and the Calgary Regional Health Authority.

Description: CUPS Community Health Centre is a non-profit, faith-based organization dedicated to serving the health, social and spiritual needs of individuals and families who lack adequate income, shelter, nutrition and social support.

The mandate of the CUPS Shared Care Mental Health Program is to provide mental health services to those suffering from mental illness among the homeless population living in Calgary's inner city. The term "homeless" includes those living on the streets or in shelters, and those at risk of being homeless, such as transients and those sharing housing. This population has a number of complex and chronic health concerns and is vulnerable, underserved and hard to serve.

Multi-level health services will be provided, using the shared care team model of health service delivery. This model is based upon the competencies within the Team to meet the needs of those being served.

Services will be provided to clients requiring transient care, primary care, selected care and outreach. Transient care clients are individuals who have access to mental health care services elsewhere in the community, but require assistance with documentation, referrals or funding for medications. Primary care clients are individuals diagnosed with mental illness who are seeking a regular, continuous source of primary health and mental health care. Selected care clients are individuals who require specialty care from the Shared Care Health Team's mental health professionals, including clients with a psychiatric diagnosis (DSM-IV), those in crisis and/or at high risk (e.g., suicide, homicide), and those with complex mental health issues (e.g., mental illness compounded by chronic illness, substance abuse, developmental delay or disability, etc.). Outreach care will be provided to clients of CUPS or inner city shelters who are identified as being at risk (e.g., suicide, eviction) and/or are suffering severe and persistent mental illness (e.g., schizophrenia, bipolar disorder), or those referred from other programs.

Thus far, efforts undertaken by the Implementation Team have focused primarily on planning and development of structures and processes for the program, differentiating

roles, and developing a format for describing clients, their outcomes and the program itself. The Evaluation Team has prepared an Evaluation Plan, including a review of the literature and completion of baseline data collection. The combined efforts of both Teams have focused on the design and development of tools to guide client intake, assessment, intervention(s) and case conferences. The objective of this work is to create forms that are user-friendly and have both clinical and research utility.

Contact:

Ms. Lorraine Melchior, Executive Director, CUPS Community Health Centre
128-7th Avenue S.E., Calgary, AB T2G 0H5
Tel: (403) 221-8780 Fax: (403) 221-8791 e-mail: cups.melchior@shaw.ca

Shared Care Clinical Outreach Service

Sponsoring Organizations: Centre for Addiction and Mental Health, Schizophrenia and Continuing Care Division
University Health Network - Toronto Western Hospital
St. Michael's Hospital

Resources: This service has 5 FTE registered nurses, 5 FTE outreach workers with a range of backgrounds including BSW, Recreation Therapist, Psychology PhD, and 1.4 FTE general practitioners (GPs) filled by an average of 7 different GPs. Consulting psychiatric sessions are provided in kind by the Centre for Addiction and Mental Health and University Health Network's Toronto Western Division for a total of .41 FTEs. Client services are further enhanced by a clinical housing worker role supported through the City of Toronto Homeless Initiatives Fund to move people from shelters to more permanent forms of accommodation.

Goals: To provide continuous medical and psychiatric services to people who are homeless and mentally ill;

To increase the number of people receiving both mental and physical health care through primary care services;

To work collaboratively with service providers to improve client access to enhanced services, thereby reducing reliance on inappropriate or fragmented services;

To promote personal safety;

To reduce hospitalization but, when necessary, provide access to beds;

To optimize people's potential for independent community living.

Description: The Shared Care Clinical Outreach Service provides medical and mental health care for homeless men and women visiting shelters and drop-in centres in the downtown Toronto area in a comprehensive, accessible and respectful manner. Services are provided in partnership with emergency hostels and shelter programs, community agencies and neighbouring hospitals. There are currently five Shared Care Teams located at nine different sites/locations. As a teaching hospital, student placements are actively supported within the Shared Care Teams. Operating on a primary care support model, Shared Care teams work collaboratively with clients and staff at each site, addressing clients' mental health, physical health and psychosocial needs. The service is free and lack of identification (Health Card) is not a barrier to treatment.

As an on-site service, a nurse and outreach worker have an office located within a hostel or drop-in. In preparation for visits from a general practitioner, they engage and assess clients who may need health care services and begin treatment. Each team's predictable hours of operation, visible location, and familiar faces strengthen communication among clients and service providers. Duplication of services is minimized while continuity and consistency of care are ensured.

A general practitioner makes routine visits to the site each week. Because the physician is on salary, lack of identification is not a barrier to treatment. The physician may also spend as much time as required providing care to a client.

A salaried psychiatrist makes regular visits as a staff consultant. The psychiatrist predominantly works indirectly with clients through consultation, education, case conferences and program development.

Key Findings: The Shared Care office is often the initial point of contact for clients and other agency staff. Clients see the Shared Care team for treatment of acute physical health problems, as well as diagnosis and treatment of serious mental health problems.

On average, Shared Care provides active treatment to 2200 individuals who are homeless and experience serious and persistent mental health problems.

Implications: On-site care in a familiar environment helps clients avoid the stigma of entering a psychiatric treatment facility, allows them to be seen on a regular basis, and builds a basis of trust facilitating treatment and enhancing clients' quality of life.

Contact: Carol Zoulalian, Manager, Shared Care Clinical Outreach Service,
Schizophrenia and Continuing Care, Centre for Addiction and Mental Health,
1001 Queen Street West, Toronto, ON M6J 1H4
Tel: (416) 535-8501 ext. 2828 Fax: (416) 583-4613
e-mail: carol_zoulalian@camh.net

Shared Care in Eating Disorders

Sponsoring Organization: Toronto General Hospital Eating Disorders Program

Starting Date: 1998

Rationale: This pilot project attempted to address the problem of long waiting times (up to six months) for initial and subsequent consultations in the Toronto General Hospital Eating Disorders Program. As well, it was difficult to locate psychiatrists and psychologists willing to perform consultations. Relatively few residents receive any specific training in this area, and there are no funds available to support the graduate training of psychologists to an acceptable standard.

Goal: To develop a collaborative working relationship between the Toronto General Hospital's Program for Eating Disorders and a variety of other physicians, including family physicians, throughout Ontario.

Description: A family physician, who had trained with the Eating Disorders Program as a resident, provides primary care eating disorder services - psychoeducation, nutrition, and a chronic support group - in her community. She sees local referrals and is, in turn, able to make referrals directly to the Program for Eating Disorders' intensive programs, thereby eliminating the patients' waiting time for initial consultation. An occupational therapist and nutritionist were trained by Program for Eating Disorders staff to assist the physician in the provision of these services.

A second satellite was set up by a family physician in the Niagara area who had developed a community-based series of basic eating disorder services in collaboration with local care providers from a variety of disciplines. She was assessing 120 new patients per year, and running a psychoeducational group, a nutrition group, a body image group and a chronic support group. The physician and two of her colleagues underwent a two-day training program at the Eating Disorders Clinic. Each of the physicians' referrals for the first year was reviewed by the Eating Disorders Clinic staff, and feedback was provided where necessary.

A third satellite is being set up in the Collingwood area, using a group family practice as the point of entry. The family physician received training at the Eating Disorders Clinic in Toronto, and the Clinic Director travels regularly to Collingwood to observe assessments and provide advice.

Key Findings: Encouraging progress has been made in the development of satellite programs. Despite some initial reservations, it has been easy to extend the program to include family physicians. It is hoped that further satellite programs will be developed to enhance the local delivery of care and to encourage greater involvement of local resources in the delivery of such care.

Contact: Dr. D. Blake Woodside, Director, Inpatient Eating Disorders Unit,
University Health Network - Toronto General Site, 200 Elizabeth Street
Toronto, ON M5G 2C4
Tel: (416) 340-4445 Fax: (416) 340-4198

HIV/AIDS Mentorship Project

Sponsoring Organization: The Ontario College of Family Physicians provides education fellowships to help defray the costs of participation in the program.

Starting Date: Spring 2001

Rationale: The OCFP recognized that patients with HIV/AIDS are living longer thanks to more effective therapeutics, and wish to receive care closer to home.

Goal: To provide family physicians with the education and ongoing support they need to manage HIV/AIDS in their practices.

Description: The Ontario College of Family Physicians and the Canadian HIV/AIDS Mentorship Program (CHAMP) have partnered to develop a unique five-day training program for family physicians who wish to incorporate patients with HIV/AIDS into their family practice.

The participants are sponsored to attend a two-day intensive workshop on HIV/AIDS. The workshop assumes a level of understanding of HIV/AIDS including assessment, diagnosis and treatment, especially pharmatherapeutics. The workshop concentrates on the psychosocial dimensions of care and expands the knowledge bases of family physicians to prepare them to deliver high quality care for HIV/AIDS patients.

Following the workshop, participants spend a day in a regional HIV/AIDS clinic. The trainee is exposed to a high volume of HIV/AIDS patients and has an opportunity to see first-hand a range of patients from early diagnosis and treatment to onset of complications to end stage. The day provides an opportunity for the trainee to establish a mentor-mentee relationship with an expert in HIV/AIDS.

On the second day in the field, the trainee is placed with a family physician who has incorporated HIV/AIDS patients into his/her practice. The day addresses the practical realities of caring for HIV/AIDS patients in community-based settings. The opportunity to establish a mentor-mentee relationship between the two family physicians is an important part of the experience.

The third day focuses on the participant's exploration of local community-based resources available in the physician's community to assist with care delivery.

While some patients may be cared for in a traditional shared care model, the program is aimed at effective CME with ongoing mentoring of the trainee by an expert in HIV/AIDS and by a family doctor experienced in the care of HIV/AIDS in a general practice as key components of the project.

Contact: Ms. Jan Kasperski, Executive Director
Ontario College of Family Physicians
357 Bay Street, Mezzanine Level, Toronto, Ontario M5H 2T7
Tel: (416) 867-9646 Fax: (416) 867-9990 e-mail: ocfp@cfpc.ca

Portuguese Mental Health and Addictions Services

Sponsoring Organization: Toronto Western Hospital

Starting Date: The program as it currently exists has been in place since the autumn of 1998; prior to that, two independent programs existed - the Kensington Clinic, and the Portuguese Mental Health Clinic.

Rationale: The Portuguese-speaking population of Ontario is not well represented with respect to mental health providers. The Clinic provides a much-needed service for a population which is underserviced due to language discordance.

Goals: To meet the mental health and addiction needs of approximately 150,000 Portuguese-speaking Ontarians;

To be accessible to family physicians and other health care providers, families, school boards, service agencies, community organizations and others wishing to refer patients with serious mental health and addiction needs.

Description: The Clinic provides both consultation and ongoing treatment of patients with severe mental illness and substance-related disorders. If the family physician is also Portuguese-speaking, care is shared, with ongoing follow-up by the family physician. Portuguese-speaking family physicians are not plentiful, however, and so the Clinic also provides ongoing care to patients with English-speaking family physicians. The Clinic has also developed strong connections with community providers in contact with the Portuguese-speaking community and shares patient care with them.

Key Findings: When patients have a Portuguese-speaking family physician, the care the Clinic provides for the patient is facilitated, and the load on Clinic resources is reduced. As well, patients are referred earlier in the course of their illness and consequently, the treatment is less complicated.

When patients have an English-speaking family physician, the shared care model has not had good success, due to the language discordance. Patients' referrals tend to occur much later in the illness with greater morbidity and, at times, mortality.

Difficulties Encountered: Community resources for Portuguese-speaking clients are limited. When the Program needs to refer a patient to a consultant or other ancillary resource not available in the Portuguese language, it becomes quite burdensome. One of the solutions has been a successful funding proposal to the Ministry of Health and Long-Term Care to fund an additional four intensive case managers to work with the Program, thus increasing the complement of clinicians working with Portuguese-speaking clients.

Contact: Dr. Jose Silveira, Director, Portuguese Mental Health and Addictions Services
University Health Network - Toronto Western Site,
399 Bathurst Street, Toronto, ON M5T 2S8
Tel: (416) 603-5974 Fax: (416) 603-5049 e-mail: jose.silveira@uhn.on.ca

Collaborative Mental Health Care

Sponsoring Organizations: Alberta Child Health Initiative
Alberta Mental Health Board
Calgary Regional Health Authority

Resources: In addition to the coordinator (1.0 FTE), the program will also employ a program evaluator (0.5 FTE), psychologist (1.0 FTE), two social workers (1.0 FTE and 0.6 FTE), two family counsellors (1.0 FTE and 0.8 FTE) and a secretary (0.8 FTE).

Starting Date: October 2000

Rationale: Primary care providers working directly in the community are in an excellent position to identify infants, children, and families who have mental health problems, or are at risk of developing them. More importantly, they are in a position to identify those at risk earlier than the more highly trained mental health professionals who typically work in tertiary care settings. Providing mental health education, intervention and referral support to primary health and child care providers will improve their ability to identify and treat mental health problems and benefit high-risk infants and children and their families.

Goals: To respond to identified needs and promote the mental well-being of infants, toddlers and preschool children (aged 0 to 6), identified as being at significant risk of developing mental health problems, and their families, through the provision of consultation and education to the primary care providers;

To provide brief intervention with identified families which incorporates treatment plans that respond to specific presenting problems and have clear, achievable treatment goals;

To monitor the progress of identified infants and children through feedback and ongoing consultation with their family, care provider or both;

To identify infants and children who exhibit symptoms that require levels of intervention beyond the mandate of the Collaborative Mental Health Care program and refer their families to the appropriate services.

To promote resiliency and reduce risk factors so that more children are socially and emotionally ready for school;

To prevent problems later in life through early identification and intervention;

To educate interested primary care providers in the community (e.g. participating family physicians, child care programs, public health nurses, child welfare workers) by providing information, workshops, and presentations relevant to their practices;

To facilitate referral and access to the Collaborative Mental Health Care program by increasing the awareness of community stakeholders and consumers through promotional activities such as visiting community health care providers and making educational presentations.

Description: To prepare for the implementation of the program, family physicians, consultants (child psychiatrists and pediatricians), and other primary care providers were invited to orientation meetings to establish links and recruit participants. A literature review was conducted, focusing on pediatric collaborative or shared care, a reference library and Telehealth module were developed, and office practices and policies, and clinical practices and procedures were established.

The types of assistance most helpful to providers of care to young children were determined (access to on-site consultation with a mental health expert to develop client-specific care plans and achievable treatment goals, to provide brief clinical

interventions, to provide education and training in mental health issues and behaviour management strategies, and to develop additional community-based resources).

Feedback was obtained from physicians and clients involved in Calgary's shared mental health care project for adults which indicated that primary care physicians value the professional consultation expertise and the psychological support provided by the consultants, particularly with patients who have complex, multiple and often entrenched problems. Rather than referral to a specialized mental health program or consultant, most patients prefer to have their primary care physician act as their mental health care provider, and most primary care physicians prefer regular on-site support.

In its first year of operation, thirty children and their families, and fifteen health and community providers were expected to participate in the program. The service was focused on a high-need area where clients may be disadvantaged but are relatively non-transient. A complex array of health and social agencies serves this community, so opportunities for collaboration are readily available.

Specially trained mental health consultants from varied backgrounds, including nursing, psychology and social work, consult with primary care providers in the primary care setting on a regular basis. The consultant may offer the provider a treatment approach or management strategy, or, if warranted, the opportunity for referral to an agency or service in the community that may better serve the child's needs. The primary care provider has regular access to the consultants by telephone or face-to-face. Funding has been established to remunerate consultants to cover non-billable time and activities.

The evaluation component of the program includes longitudinal follow-up, outcome measures related to social, medical and psychological factors, service utilization, family and child demographics, treatment goal achievement and satisfaction measures.

Lessons Learned: Many mental health care providers have a poor sense of infant mental health, and of the critical importance of early intervention. As well, time and energy are required to establish the relationships which form the foundation for consultation.

Difficulty Encountered: Convincing family practitioners of the benefits of becoming involved with the program has, at times, been challenging.

Contact: Mr. Keith Donaghy, Coordinator, Collaborative Mental Health Care
Tel: (403) 541-2103 e-mail: keith.donaghy@crha-health.ab.ca

Seniors' Mental Health Program - Community Service

Sponsoring Organizations: North Bay Psychiatric Hospital
Ontario Ministry of Health and Long-Term Care

Resources: There are approximately 2.2 FTE geriatric psychiatrists (filled by 4 different psychiatrists), 0.6 FTE GP-geriatrician and approximately 2.2 nurse-clinicians in the base program, and 4 FTE regional outreach nurses. The GP-geriatrician also functions as the Acting Medical Director and a Program Manager is shared with the Seniors' Mental Health Inpatient Program.

Starting Date: 1993. The shared care model has been evolving since 1996.

Goals: To provide mental health assessment, diagnosis, treatment recommendations, limited follow-up and/or referral on an outreach basis for people with age-related mental health problems;

To collaborate with health care agencies and caregivers (formal or informal) to ensure that the mental health needs of the elderly are met;

To provide consultation and education to community agencies as well as to other health professionals concerned with geropsychiatric problems;

To provide advocacy for clients and their families in their relationship with the community;

To prevent hospitalization when possible, and, when hospitalization is necessary, to reduce the trauma of hospitalization and enhance the effectiveness of the overall treatment program by preparing the patient and family;

To facilitate rehabilitation and reintegration of hospitalized clients into the community.

Description: The team functions as an interdisciplinary team using a shared care model when possible. This reflects the large catchment area served - it is not possible to deliver primary psychiatric care over such a region, especially in the absence of well-developed telemedicine resources.

Patients referred by their GPs are visited by the team in homes, long-term care facilities and sometimes general hospitals. The team endeavours to provide peer education, with nurses acting as teaching resources to the nursing staff of long-term care facilities, using both didactic and informal teaching methods. The physicians endeavour to varying degrees to collaboratively support GPs in their care of the elderly with mental health needs, through didactic lectures, informal discussion, and primarily "teaching consultations". These are consult reports that outline how a given diagnosis was arrived at, and the reasoning behind interventions and medications recommended, as well as detailed information on how to use and monitor them. The approach varies with the consultant (individual preference), as well as the consultee, as not all GPs are equally enthusiastic about a shared care / teaching model.

The program serves a vast area of northeastern Ontario. Referrals within a few hours' drive of the base program in North Bay are discussed and assigned in weekly Intake Conferences, and seen in turn, except when a more urgent visit is clinically indicated (though the Program does NOT offer itself as an emergency service). Eight different sites are visited each month for between one and three days each.

At this time, patients are not seen in general practitioners' offices, although this is being considered. Widespread change is imminent as the North Bay Psychiatric Hospital is divested, and merged with Sudbury-Algoma Hospital and Network North to form the North-East Mental Health Centre.

Lessons Learned: Different communities have received the model very differently. In general, those in larger, more southern centres tend to prefer the more traditional "transfer of care" model, and may see patients with mental illness as "belonging" to the psychiatric hospital, although this varies widely from GP to GP. Again, as a generalization, younger GPs may be more open to the collaborative model than GPs nearer the end of their professional lives.

Difficulties Encountered: The possibility of seeing patients in their GPs' offices has been broached a couple of times, and the main concern from GPs has been loss of time without reimbursement from their billing practices. An integrated model like the Hamilton HSO Mental Health Program may be ideal for a setting such as this.

Implications: Creative funding sources must be developed for GPs not funded by capitation.

Contact: Dr. Anysia Rusak, North Bay Psychiatric Hospital
Tel: (705) 494-3054 or (705) 474-1200
e-mail: arusak@mcmaster.ca or anysia.rusak@nbph.moh.gov.on.ca

Crisis and Relapse Prevention Service Rural Shared Care Project

Resources: The treatment team is staffed by eight nurses and four psychology staff (two MAs and two PhDs) and one consultant psychiatrist. The Director is a senior psychologist.

Starting Date: 2000

Goals: To keep the individual functioning in the community, bring preventative intervention to bear at the point when crises are being experienced, and minimize hospitalization by strengthening links between a crisis service and community family physicians.

Description: The focus of the Crisis and Relapse Prevention Service includes crisis and suicidal risk treatment, brief therapy for stabilization for the acute state and relapse prevention. The service conducts screening, assessment and therapy providing ambulatory services to individuals with acute psychotic and affective disorders, serious anxiety disorders, and personality disorders, according to the severity of their dysfunction. The rural shared care project is one of an array of preventative and acute ambulatory treatment services.

17 of 33 family physicians in Elgin County participate in the program. The project involves a visit once every six weeks to discuss the progress of cases seen by the Crisis Service. Literature on user-friendly topics is made available and periodic CME events have been organized. Immediate contact is made with the client's family physician on every admitted case for which the client gives signed permission. A faxed face sheet is sent on initial assessment and discharge. If medication is used, the family physician is encouraged to implement the prescription and monitor the client's progress following consultation.

Contact: Dr. J. .D. Mendonca, Director, Crisis & Relapse Prevention Service
Regional Mental Health Care St. Thomas
467 Sunset Drive, P.O.Box 2004, St. Thomas, ON N5P 3V9
Tel: (519) 631-8510 ext. 2214 Fax: (519) 631-2512

Education

A key to the continuing success of shared care will be our ability to produce graduates of our training programs who recognize the importance of collaboration and have the skills - and inclination - to develop collaborative relationships with colleagues from other specialties.

To assess the extent to which this is currently taking place, a major project of the National Collaborative Working Group has been a survey of the current stage of training in shared care in Canadian family medicine and psychiatry residency programs and the ensuing development of training guidelines for residency programs. Findings from this survey are included in a summary of this project.

To date, training in the concepts and practice of shared care has figured more prominently in family medicine than psychiatry residency programs. In the former, mental health care is often integrated into clinical rotations in the primary care setting, with a visiting psychiatrist working closely with that unit. Program descriptions in this section outline how this is put into practice, including two programs that focus on teaching skills in working with children with mental health problems. It is encouraging, however, that we are now beginning to see initial steps towards formalizing training for psychiatry residents to help them develop skills that will prepare them to work more effectively with primary care physicians.

This section also includes a description of a program in Nova Scotia where the emphasis has been on teaching collaborative skills to medical students. This is an important new direction as the more familiar graduating physicians are with principles of collaboration (irrespective of their choice of specialty), the more likely they are to apply these principles during their residency training and incorporate them into their post-residency practice.

Survey of Canadian Family Medicine and Psychiatry Residency Programs to Examine the Extent to Which Concepts of Shared Care Are Being Taught

Sponsoring Organization: CPA/CFPC Collaborative Working Group on Shared Mental Health Care

Rationale: The CPA and CFPC 1997 position paper on shared mental health care in Canada 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.

To further understand this issue, the Collaborative Working Group set up to implement the recommendations of the Report conducted a survey of the program directors of all Canadian family medicine and psychiatry programs to determine the current training experience of residents in shared mental health care.

Goals: 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 programs are responsible for the teaching of psychiatry/behavioral medicine to family medicine residents and vice versa.

Description: A questionnaire for psychiatry program directors was developed based upon the objectives and piloted. It was then sent to the program directors of the 16 psychiatry residency programs in Canada. The initial mailing was followed with a second mailing and telephone calls. Eventually 14 of a possible 16 responses were received.

A modified version applicable to family medicine programs was developed and distributed by the CFPC to the program directors of the 16 family medicine programs in Canada approximately six months following the psychiatric survey. 15 of a possible 16 surveys were returned.

Key Findings: Most program directors in both specialties were aware of the joint position paper. In many family medicine programs it had been used to develop goals and objectives for training. 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 had a visiting psychiatrist to assess / discuss cases. Some commented that this did not happen frequently enough. Some psychiatry residents participated in this at some point in their training. There was considerable variation in the type of experiences available.

There appeared 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 practices 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 the theory and practice of shared mental health care as well as for teaching materials, current references on shared mental health care, and training objectives and additional human resources to teach shared mental health care.

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 feedback. The Working Group has also developed a list of current references on shared mental health care, including references for education and training. A national database of individuals interested or involved in shared mental health care activities has also been developed and is available as a reference.

Lessons Learned:

It was recommended that the Working Group should:

- Continue to work with program directors to finalize the learning objectives and 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 programs;
- Develop strategies to assist residency program directors in meeting the needs identified in the survey, e.g., provide suggestions for topics for tutorials and seminars;
- Maintain 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;
- Work 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.

Contact:

Dr. Roger Bland, University of Alberta H-Site
8440 - 112 Street NW, Edmonton, AB T6G 2B7
Tel: (780) 407-6570 Fax: (780) 407-6804 e-mail: roger.bland@ualberta.ca

McMaster Family Medicine Residency Behavioural Science Training

Sponsoring Organization: Department of Family Medicine, McMaster University (funding)

Starting Date: 1975

Goals: To provide Family Medicine residents with the knowledge and skills to effectively manage mental health problems they will encounter in their practices;

To integrate the teaching of behavioural science with residents' daily activities in their clinical placement.

Description: Throughout their two-year training, family medicine residents attend behavioural sciences training 1/2 day each week at their family medicine site, instead of having a block placement. The residents' training in behavioural sciences is composed of the academic half-day and ongoing supervision from a Family Medicine supervisor. Teaching takes place in small groups with tutors who come from a variety of professional backgrounds. Various teaching modalities and methodologies are employed; teaching is case-based, whenever possible. Each resident also has a family physician as their clinical supervisor. The supervisor acts as mentor, support, role model and reinforcer of the learning that takes place in the academic half-day.

The curriculum centres on commonly-encountered family medicine problems, such as managing life cycle events, adjustment to physical illness and family problems. Managing psychiatric illnesses is also covered. Residents are trained to develop skills in basic communication techniques common to all patients, as well as specific assessments of emotional problems and their management. Residents spend approximately 250 to 300 hours in the behavioural science tutorial over the two years of the program, depending on their out-of-town placements.

Evaluation is an obligatory part of the program, and is carried out for each resident and tutor, and for the program as a whole.

Tutors from each of the teaching centres meet every two to three months to plan changes to the program, and to share useful strategies and resources. The Departments of Family Medicine and Psychiatry have also each identified a faculty member who serve as joint coordinators of the behavioural science training and who meet monthly.

Key Findings: The longitudinal nature of the rotation encourages a case-based format, and allows residents to develop skills in assessment and treatment. It can, however, be difficult for residents to free the time from another rotation in order to return to a Family Practice Unit for a half-day.

Evaluations carried out in the program suggest strongly that residents react positively to strong involvement by family physicians, both in the small groups, and in day-to-day patient care experiences. As well, resident satisfaction has been shown to be high.

Lessons Learned: The importance of a family physician's involvement in the teaching of behavioural science issues cannot be over-emphasized. Family physicians are essential role models for residents as they demonstrate the importance of integrating behavioural science principles with day-to-day office practice. The psychiatrist also plays a critical role, acting as an educational resource, modeling interviewing and assessment skills and a collaborative working relationship with the family doctor.

Implication: The key to successful teaching lies in the collaboration between the family physician and the psychiatrist, in planning as well as implementing the program.

Contacts: Dr. Nancy Fowler, North Hamilton Community Health Centre,
554 John Street North, Hamilton, ON L8L 4S1
Tel: (905) 523-6611 Fax: (905) 523-5173 e-mail: fowlern@mcmaster.ca

Dr. Jon Davine, East Region Mental Health Services,
2757 King Street East, Hamilton, ON L8G 5E4
Tel: (905) 573-4801 Fax: (905) 573-4802 e-mail: davinej@mcmaster.ca

University of Manitoba Family Medicine Residents' Training

Sponsoring Organization: Department of Family Medicine, University of Manitoba

Description: There is no separate Psychiatry rotation over the two-year Family Medicine program. Psychiatry is integrated into the Family Medicine block time rotations.

The psychiatrist sees patients referred from the academic teaching units 0.1 days per week with a Family Medicine resident present. Residents see patients from their home academic clinics, ideally ones they have referred themselves, although the timing rarely works out that way. One morning per week, the psychiatrist runs a series of workshops and lectures for the residents on Family Medicine block time.

Instead of psychiatry rotations, residents have 'community experiences' in their second year, spending time with child psychiatrists at the adolescent treatment centre, and some time with the inpatient consult service, all as part of their Family Medicine block time.

Key Findings: The lectures are well attended and evaluated positively.

Lessons Learned: A psychiatrist who supports and empowers Family Medicine residents rather than assuming control has allowed residents to care for patients with significant morbidity.

Family Medicine residents seem to prefer to learn about psychiatric care issues in a primary care environment.

Contact: Dr. Brent Kvern, Family Medical Centre
500 - 400 Tache Avenue, Winnipeg, MB R2H 3E1
Tel: (204) 237-2863 Tel: (204) 231-2648 e-mail: bkvern@cc.umanitoba.ca

Psychiatric Training of Family Medicine Residents

Sponsoring Organizations: University of Montreal, Family Medicine Unit at CLSC des Faubourgs
Notre-Dame Hospital of CHUM

Funding: There is no special funding. All participants are involved with the teaching of medical students, family medicine or psychiatry residents.

Starting Date: Collaboration with psychiatrists started in July 2000; the expected starting date for collaboration with child psychiatrists is April or May 2001.

Goals: To provide Family Medicine residents with clinical psychiatric teaching in settings where the referrals are relevant to their future practice;

To improve residents' evaluation skills by practising under direct supervision;

To give residents a realistic sense of the practice of psychiatry;

To enable residents to learn how to make a referral to fit their needs as a referring physician;

To expose residents to role models.

Description: Over the course of the two year program, family medicine residents spend four half-days at PSPP for joint evaluation of primary care referrals, one half-day in child psychiatry for joint evaluation of primary care referrals, two half-days for case discussions in small groups with an invited psychiatrist (one for difficult cases and the other for child psychiatry), and two half-days at the Psychiatric Emergency Room per six months (horizontalized) per year.

A committee composed of two psychiatrists from CHUM's Psychiatry Department (plus possibly one child psychiatrist) and two family physicians from the Family Medicine Units will review clinical teaching opportunities for Family Medicine residents in the Department and possibly draft a psychiatric curriculum within the Family Medicine horizontalized rotations.

Key Findings: The level of resident satisfaction has been high, as has the level of relevancy for future practice and needed skills. The program provides a very advantageous one-to-one teaching format and exposure to a wide range of psychiatric problems. Continuity of care, collaboration and competency in dealing with mental health problems are enhanced.

Lessons Learned: The psychiatrists should plan clinical time in their schedules without residents. Residents should be encouraged to take an active role even if they are observing an evaluation.

Difficulties Encountered: This model of care is very demanding for the psychiatrist involved. Time the psychiatrist would normally spend writing a case report after evaluation is instead spent in discussion with family medicine residents. Because the participation of residents is limited to a half-day, it is difficult for them to contribute to the writing of the report.

Contact: Dr. Sophie Galarneau, CLSC des Faubourgs, 2260 Parthenais, Montreal QC H2K 3T5 Tel: (514) 527-4929 ext. 340 e-mail: sogalarneau@hotmail.com

Teaching Child Psychiatry to Family Practice Residents at the University of Western Ontario

Sponsoring Organizations: Department of Family Medicine, University of Western Ontario
Division of Child Psychiatry, Department of Psychiatry, University of Western Ontario

Goals: To educate family practice residents with respect to a variety of common mental health problems in children;

To teach family practice residents about treatment strategies for children's mental health problems such as pharmacotherapy, psychotherapy, and family therapy;

To teach family practice residents about when to refer children with mental health problems to mental health professionals;

To expose family practice residents to interviewing children and adolescents with mental health problems.

Description: A child psychiatrist visits one of three family medicine practice centres once a month. The visits range from 75 minutes to three hours and are attended by family practice residents, family physicians, nursing staff and medical students. At one centre, a family medicine resident discusses a case. The child psychiatrist conducts a consultation behind a one-way mirror and then a group discussion occurs with respect to diagnosis and management. At a second centre, the approach is predominantly didactic teaching. At a third centre, there are a variety of experiences. At each session, the resident presents a case from his/her own practice. Sometimes the teaching is an interactive discussion with the child psychiatrist. During other sessions, residents request a didactic learning session, or the resident brings in a child to be interviewed by the psychiatrist. At other times, there are videotapes of the resident interviewing a child.

Key Findings: This program has been well received by family practice residents and family physicians.

Implications: Since child and adolescent mental health problems are common and since there are very few child psychiatrists, teaching family practitioners to identify and manage children's common mental health problems will improve the mental health of children and make optimal use of referrals to child psychiatrists.

Contacts: Dr. Margaret Steele, Children's Hospital of Western Ontario
Child and Adolescent Centre
London Health Sciences Centre, Health Services Building
346 South Street, London, ON N6A 4G5
Tel: (519) 667-6671 e-mail: margaret.steele@lhsc.on.ca

Dr. Gordon Dickie Tel: (519) 672-9660 e-mail: gldickie@uwo.ca

Publications: Fisman S, Sangster J. Steele M, Stewart M, Rae-Grant N. Teaching Child and Adolescent Psychiatry to Family Medicine Trainees: A Pilot Experience. Can J Psych 1996; 41:623-628.

Steele M, Dickie G. Child and Adolescent Psychiatry Teaching in Family Practice Residency Training Programs: The Canadian Experience. Canadian Child Psychiatry Review 1997; 6:100-105.

Teaching Child Psychiatry to Rural Family Practice Residents

Sponsoring Organizations: Department of Family Medicine, University of Western Ontario
Division of Child and Adolescent Psychiatry, Department of Psychiatry, University of Western Ontario

Funding: Department of Family Medicine, University of Western Ontario

Starting Date: June 2, 1994

Goals: To educate family practice residents with respect to a variety of common mental health problems in children;

To teach family practice residents about treatment strategies for children's mental health problems such as pharmacotherapy, psychotherapy, and family therapy;

To teach family practice residents about when to refer children with mental health problems to mental health professionals;

To expose family practice residents to interviewing children and adolescents with mental health problems.

Description: Once a month, four to six rural family practice residents travel to London, Ontario. They are first able to observe an interview with a child and adolescent conducted by a child psychiatrist. In five subsequent visits, each one of the residents interviews a child or adolescent with a mental health problem. The patients come from the Inpatient Unit of the Child and Adolescent Psychiatric Unit at the Children's Hospital of Western Ontario. The residents' interviews are critiqued by their peers and by the child psychiatrist. Diagnosis and treatment are discussed, focusing on how the rural family physician would manage children's common mental health problems.

Key Findings: Evaluations by the rural family practice residents have been extremely positive.

Implications: Since child and adolescent mental health problems are common and since there are very few child psychiatrists, teaching family practitioners to identify and manage children's common mental health problems will improve the mental health of children and make optimal use of referrals to child psychiatrists.

Contact: Dr. Margaret Steele, Children's Hospital of Western Ontario
Child and Adolescent Centre
London Health Sciences Centre, Health Services Building
346 South Street, London, ON N6A 4G5
Tel: (519) 667-6671 e-mail: margaret.steele@lhsc.on.ca

Publications: Fisman S, Sangster J, Steele M, Stewart M, Rae-Grant N. Teaching Child and Adolescent Psychiatry to Family Medicine Trainees: A Pilot Experience. Can J Psychiatry 1996; 41:623-628.

Steele M, Dickie G. Child and Adolescent Psychiatry Teaching in Family Practice Residency Training Programs: The Canadian Experience. Canadian Child Psychiatry Review 1997; 6:100-105.

Family Medicine North - Behavioural Science Training

Sponsoring Organizations: Department of Psychiatry and Department of Family Medicine, Family Medicine North

Funding: Northern Ontario Medical Program

Starting Date: 1991

Rationale: The program developed to provide core psychiatric training experience modeled on the Family Medicine program at McMaster University in Hamilton, Ontario.

Goal: To provide a useful exposure to the behavioural science issues encountered in family practice.

Description: There are weekly half-day tutorials throughout the two years of residency training, equivalent to a six-week rotation. The tutorials for each year are conducted by a family physician and psychiatrist. Most of these tutorial sessions follow a problem-based approach, during which live interviews, role-playing, or, rarely, videotapes are used as the basis for discussion of behavioural science issues. These issues include the major psychiatric disorders, as well as issues encountered in a family practice office such as breaking bad news, family violence and the difficult patient.

There has been ongoing collaboration between the Family Medicine North program and the McMaster University program. Dr. Jon Davine of the McMaster program has visited Thunder Bay to provide teaching expertise, and representatives of the Family Medicine North program have attended problem-based learning and tutorial sessions, as well as Behavioural Science meetings at McMaster. Numerous discussions between the two groups have taken place. The Family Medicine North program has also made use of a number of local and distant resources to bring in invited speakers on a variety of topics that residents have found helpful.

Key Findings: Residents generally acquire significant knowledge and skills in the current behavioural science training program. They have generally performed well on their simulated office oral experience, a mandatory part of the behavioural science learning, and on their CCFP exams. A study of the experiences of current and former family medicine residents with the behavioural science program has been carried out and, overall, the results were positive.

Difficulties Encountered: There has been some reluctance by residents, and to some extent, their supervising preceptors, to provide videotapes from their clinical rotations, despite the installation of the necessary equipment in each of the participating family medicine preceptors' offices. For this reason, the program relies more heavily upon live interviews with patients and role-playing.

Another difficulty has been the nature of the program, which requires a significant portion of mandatory and elective experiences outside Thunder Bay, resulting in some residents missing a significant portion of their behavioural science tutorials. Although videotaping and audioconferencing of the sessions have been used on a limited basis, residents are encouraged and assisted to find resources in the communities in which they are based for behavioural science learning on an ongoing basis.

It has also been difficult to assess residents on the basis of the limited number of observed interviews possible, particularly with recent expansion of the program to include 14 residents yearly. Family medicine preceptors are also encouraged to observe interviews and provide feedback. A related concern is the lack of information on the resident's ability to manage psychiatric issues on an ongoing basis. Because of this, other horizontal and vertical elective experiences with psychiatrists in the program have been offered and encouraged, both in Thunder Bay and in the outlying communities to which residents travel. Finally, a lack of psychiatric manpower has made it challenging to provide a full-time psychiatric tutor to the first-year residents.

Contact: Dr. Suzanne Allain, Lakehead Psychiatric Hospital, P.O. Box 2930, Station P, Thunder Bay, ON P7B 5G4
Tel: (807) 343-4300 Fax: (807) 343-4387

Training Psychiatry Residents in Shared Care at McMaster University

Sponsoring Organization: Department of Psychiatry and Behavioural Neurosciences, McMaster University

Rationale: Psychiatry residents receive very little training in working with primary care physicians (on average, two hours of formal training during an entire residency), even though after graduation, family physicians will be a major referral source and many opportunities will present for sharing care. The residency program may be the best place to develop the skills and attitudes to further collaboration in practice.

Goals: To raise psychiatry residents' awareness of the importance of collaboration with family physicians in their practice;

To teach skills and attitudes to residents that will strengthen their skills in collaborative practice description.

Description: The McMaster program has a number of components. These include:

(a) didactic seminars in the first and third years of residency training;

(b) opportunities to join a psychiatrist who is consulting to a family practice clinic, usually integrated with an outpatient or child psychiatry rotation;

(c) opportunities to participate in the training program for Family Medicine residents;

(d) electives that can involve participating in continuing education activities for family physicians, research projects or further time working in primary care settings;

(e) modeling of and support for collaboration by clinical supervisors, many of whom spend part of their month working in primary care settings.

Key Findings: Residents appreciate the opportunity to work with primary care physicians and residents and to learn about the roles of primary care in the health care system. This is something that they are frequently unaware of, particularly as they may have spent very little time in clinical practice before entering their residency. Residents usually find that half a day per week working in primary care, integrated with another rotation, is sufficient to give them an understanding of the demands and nature of cases in primary care and to develop skills in consultation/collaboration. Residents are surprised at the wide range of cases seen in primary care, including many individuals with serious mental illness and problems not commonly encountered in more specialized outpatient services.

These rotations also enable residents to be screened on all the cases they assess and to observe their supervising psychiatrist conduct consultations (something that rarely happens in other rotations) as well as model collaborative communications/case reviews with family physicians.

One or two seminars during the residency appear sufficient to teach basic principles and practices of shared mental health care, if these are reinforced by related clinical experiences.

Contact: Dr. Nick Kates, 40 Forest Avenue, 2nd floor, Hamilton, ON L8N 1X1
Tel: (905) 521-6133 Fax: (905) 521-6107 e-mail: nkates@mcmaster.ca

Reference: Kates N. Sharing mental health care: Training psychiatry residents to work with family physicians. Psychosomatics 2000; 41(1):53-57.

Training Elective for Psychiatry Residents in Primary Care Consultation Liaison

Sponsoring Organization: Department of Psychiatry, University of Toronto Psychiatry Residency Training Program

Starting Date: July 1, 1996

Rationale: Within the traditional psychiatry residency program at the University of Toronto, there is limited involvement with family medicine and very little opportunity for outpatient consultation to family medicine. The majority of resident training rotations in psychiatry involve working on psychiatric services or occasional consultation to hospital inpatients and some outreach mental health community programs. This elective training program was initiated to provide an opportunity for residents to gain clinical experience working with family physicians in a shared care outreach consultation model.

Goals: To provide an opportunity for psychiatry residents to become involved with shared care consultations with family medicine;

To provide an opportunity to participate in community outreach visits under the supervision of a psychiatrist trained in the shared care model and to focus on specific skills;

To provide feedback on the participating trainee's skills.

Description: Psychiatry resident trainees spend 1/2 day per week doing family practice liaison and outreach under the direction of a psychiatrist. As of August 2000, there had been four psychiatry resident trainees from the University of Toronto who participated in this elective.

Key Findings: Trainees have found the experience highly valuable. Differences were described in the clinical role of the psychiatrist in a shared care primary care community liaison model of service delivery as compared to their other experiences within tertiary care academic training centres in which they spend the rest of their training time.

Lessons Learned: These appear to be valuable training experiences for residents distinct from those offered in the academic setting and valuable for meeting the needs of psychiatry trainees to provide psychiatric consultation when they graduate to their future positions.

Difficulties Encountered: Currently, this program can only be offered as an elective rotation or as a career track elective for psychiatry residents. It involves shifting manpower from traditional psychiatric rotations to work in the community with family physicians.

There have been few clinical supervisors to train the residents as very few psychiatrists have been exposed to or have specific expertise in the shared care model. This was largely resolved by training only one resident at a time, and by having a psychiatrist experienced in shared care and primary care outreach serve as the elective supervisor.

Implications: This program suggests that residents can successfully gain clinical training experience working in family practice settings and gain exposure to a shared care model. The expertise and awareness developed by residents in primary care consultation will enable them to provide this clinical service in their future community practices and to serve as role models and supervisors to future trainees.

Contact: Dr. Thomas Ungar, Department of Psychiatry, North York General Hospital,
4001 Leslie Street, 8th Floor, North York, ON M2K 1E1
Tel: (416) 756-6655 Fax: (416) 756-6671 e-mail: tungar@nygh.on.ca

Dalhousie University Family Medicine/Psychiatry Clerkship Program

Sponsoring Organization:	Dalhousie University
Starting Date:	September 1999
Rationale:	This interdisciplinary program was developed in order to better prepare medical students to practise in a health care system which increasingly requires a more integrated approach.
Goal:	To provide clinical clerks with a learning experience that integrates psychiatry and family medicine and demonstrates collaboration and continuity of care.
Description:	Family medicine residents spend twelve weeks in an integrated behavioural medicine and primary care block, consisting of four weeks of family medicine core, four weeks of core psychiatry and a four-week choice block. Students may choose to do extra time in family medicine or psychiatry, or they may choose to do what is called a "blended" rotation. Blended rotations are designed to reflect a shared mental health care model.
Key Findings:	To date, evaluations of the block have been very positive.
Lessons Learned:	Particularly for the blended rotations, there is a need for faculty development for both the family physicians and the psychiatry teachers in the community. The most successful blended rotations have been in locations where a shared mental health care program was already established.
Difficulties Encountered:	Developing psychiatry / family medicine pairs in the community has proven to be challenging. It has been difficult to find pairs that are located sufficiently close to one another to enable clerks to follow patients as they navigate through the system. Providing the faculty development has also been difficult, and a working committee continues to develop the program.
Implications:	In order to facilitate more blended rotations, alternative methods of remuneration, other than fee-for-service, must be sought for community-based teachers. This will involve discussions with the Medical Society and the Provincial Government.
Contact:	Dr. Cathy MacLean, Director, Undergraduate Medical Education, Department of Family Medicine, Dalhousie University QEII HSC, Abbie J. Lane Memorial Bldg., 8th Floor 5909 Veterans' Memorial Lane, Halifax, NS, B3H 2E2 Tel: (902) 473-4747 or 1-800-319-9089, Fax: (902) 473-4760 Website: http://www.dal.ca/~fmwww/

Continuing Education

Periodically, most communities will organise a continuing education event for family physicians on a mental health topic, although these are usually "one time" events. This section includes descriptions of programs that have aimed to develop a more systematic approach to education of family physicians. These have included regular evening courses, additional training in psychotherapy and a week-long course for family physicians on managing mental health problems.

In addition to these events, there is another group of educational activities that has taken a different approach to continuing education. The goal of these projects is to provide comprehensive information for family physicians around a particular problem or disorder commonly encountered in primary care, using a variety of modalities. These have included telephone information lines, the preparation of guidelines and care pathways, the production of information manuals, training workshops and a combination of all of the above methodologies to reach family physicians and enhance their skills and knowledge.

This section also features larger outreach projects that have taken responsibility for continuing education as part of a broader mandate, such as MHECCU in British Columbia.

Traditionally, continuing education programs have put most of their emphasis on teaching family physicians specific skills in the detection and management of mental health problems in their practice. They rarely focus on the importance of collaborative skills, or how care can be shared between mental health and primary care providers. It is also unusual to find continuing education sessions for psychiatrists that focus on sharing care or working with primary care providers. There are encouraging signs from some of the programs described in this section, however, that this is starting to change.

Primary Care Psychiatry Course

Sponsoring Organizations: Centre for Addiction and Mental Health
University of Toronto

Starting Date: October 1996

Goals: To refine psychiatric diagnostic and psychopharmacologic skills of family physicians;

To expose family physicians to cognitive behaviour therapy;

To strengthen links between mental health and primary care services;

To support the role of primary care providers in delivering mental health care.

Description: 16 family physicians are enrolled in this course, attending one session per month for eight months. Depression, bipolar disorder, panic disorder, and obsessive-compulsive disorder are the main foci, along with minor related disorders. The format of the course blends didactic training with case-based discussion, and an opportunity for physicians to test skills in their own practices and discuss such applications in class with ongoing supervision. Diagnosis, medications, and psychosocial interventions all receive attention.

Key Findings: The course has been evaluated through use of satisfaction scales, knowledge questionnaires, self-reports of skill change, and evaluations of changes in practice. All these measures have shown that the course has had a substantial impact. Physicians in the course have begun to treat some disorders (bipolar and OCD) that they did not treat previously, and enhanced their treatment of other disorders.

The course has received international attention, with presentations in several centres. In 1999, it won the international award for "Best Live CME Presentation" by the Alliance for Continuing Medical Education. The course previously won awards for best CME program in the Department of Psychiatry (1998) and the University of Toronto Faculty of Medicine (1997).

Implications: Carefully-designed CME programs can alter family physicians' knowledge, skill, and practice behaviour, and enlarge the capacity of the primary care sector to manage patients with mental disorders.

Contact: Dr. Sagar Parikh, Centre for Addiction and Mental Health
250 College St., Toronto, ON, M5T 1R8
Tel: (416) 979-6946 Fax: (416) 979-6864 e-mail: sagar_parikh@camh.net

Small Group Problem-Based Learning in Primary Care Settings

Funding: The program is supported by the Hamilton HSO Mental Health & Nutrition Program.

Rationale: Family physicians working in the HSO Mental Health Program identified the potential benefits of meeting with a psychiatrist/mental health professional on a regular basis to discuss problems with clients in their practices.

Goal: To increase family physicians' skills and comfort in managing mental health problems of patients they see in their practices.

Description: The small group sessions take place approximately monthly (nine times a year). The participants are psychiatrists and family physicians working in the Hamilton HSO Mental Health & Nutrition Program. Sessions are accredited by the College of Family Physicians of Canada for MAINPRO-C credits and include a brief presentation on a topic chosen by the family physicians, usually introduced by a psychiatrist, followed by discussions of cases being seen by the family physicians related to the topic. Topics covered have included managing chronic pain, changes to Ontario's Mental Health Act, eating disorders, attention deficit disorders in children and adults, competency, bipolar disorder, schizophrenia, panic disorder, social phobia, new antipsychotic medications, chronic fatigue syndrome and managing psychiatric emergencies.

Sessions are coordinated by family physicians in conjunction with a psychiatrist and usually take place over lunchtime. A relevant article is circulated prior to the sessions, which are open to all family physicians participating in Primary Care Reform in Hamilton.

Key Findings: Approximately 50 family physicians have participated in one of five small groups which have now been meeting for two years. Attendance remains high.

The groups work well and have assisted family physicians in meeting their accreditation requirements. All articles used by the groups are compiled centrally, which makes it much easier for other groups wishing to study the same topic, as they have easy access to these materials.

Difficulty Encountered: The major problem has been for family physicians to get away from their offices to attend a lunchtime meeting - providing lunch and MAINPRO-C credits helps.

Implications: The small groups have been easy to organise and have been well received by the participants. Similar programs could be organised in other communities. It is important that there is an expectation to attend, with a closed list of members, rather than the groups being run on a "drop-in" basis.

Contact: Dr. Nick Kates, 40 Forest Avenue, 2nd Floor, Hamilton, ON L8N 1X1
Tel: (905) 521-6133 Fax: (905) 521-6107 e-mail: nkates@mcmaster.ca

Psychiatry for Family Physicians, McMaster University Evening Seminars

Sponsoring Organizations: McMaster University Department of Psychiatry and Behavioural Neurosciences
Pharmaceutical Companies

Starting Date: September 1999

Goal: To increase family physicians' knowledge and skills regarding psychiatric issues relevant to their clinical practice.

Description: Two series of seminars are run, each holding one session per month on Monday evening from 4:30 to 6:30 p.m. Each session is run by a facilitator from the Department of Psychiatry, and needs assessment tools are used to develop topics and goals for each session. The program uses a small group case-based learning model and group interaction is encouraged.

The sessions are evaluated immediately and an impact on practice evaluation questionnaire is completed approximately three months after the end of the year's course of sessions. The program is approved for MAINPRO-C Credits by the College of Family Physicians of Canada.

Topics covered in these sessions have included the management of mood disorders, anxiety disorders, attention deficit disorder, addiction, chronic pain, eating disorders, sleep disorders, childhood disorders, psychiatric emergencies, and schizophrenia.

Key Findings: Over the last two years, more than 60 family physicians have participated in one of the two series. Evaluations have been extremely positive with 95% satisfaction rating with the content of the sessions and the presentation format. Family physicians also felt that the program has had a positive impact on their clinical practice.

Lessons Learned: Small group, problem-based learning is an effective way of assisting family physicians to increase their skills and comfort in handling mental health problems encountered in their practices. The 4:30 (end of the clinical day) timing appears to be appreciated by participants.

Contact: Dr. Jon Davine, East Regional Mental Health Services,
2757 King Street East, Hamilton, ON L8G 5E4
Tel: (905) 573-4801 Fax: (905) 573-4802 e-mail: davinej@mcmaster.ca

North York General Hospital Annual Mental Health Clinic Day

Sponsoring Organization: Department of Family Medicine, North York General Hospital
Department of Psychiatry, North York General Hospital

Starting Date: 1997

Rationale: This event was developed in order to fill a gap in continuing education for family physicians. Based on a questionnaire of family physician learners, as well as information obtained from discussions with the Chiefs of the Departments of Psychiatry and Family Medicine, it was determined that a practical clinic day was needed.

Goal: To provide a continuing education clinic day to the Department of Family Medicine in collaboration with the Department of Psychiatry to improve knowledge and skills with respect to mental health issues in primary care.

Description: The event consists of a half-day (usually Wednesday morning) that features a series of short educational talks on a variety of psychiatric topics. The purpose of the talks is not to provide an overwhelmingly specialty-oriented approach, but to provide practical review and continuing education information to improve the knowledge and skills of family physicians in managing the mental health problems of their patients. The event was first held in 1997, and was repeated in 1998 and 2001.

Key Findings: The event has been well attended, with 60 to 70 family physicians participating each time.

Lessons Learned: Primary care physicians preferred a half-day, usually mid-week, continuing education event, with short topic lengths and a goal- and problem-solving-oriented approach. By planning the event from the beginning in full collaboration with the Department of Family Medicine, the event has remained relevant and successful.

It was important to ensure that this educational event for family physician learners was planned equally by the family physicians. The event was co-chaired and co-developed by the two Departments from start to finish. Revenues generated from the event were equally shared by both Departments. It was important to choose planners who were able to work collaboratively..

Implications: A jointly-developed ongoing continuing education event for family physicians in mental health can be successfully delivered. As family physicians increase their role in the delivery of mental health care, the demand for continuing medical education will keep growing. Other members of the mental health care delivery teams will also require ongoing continuing education. Further programs should always involve family physicians in the development of the program from start to finish, so as to ensure such programs address the learning needs of participants.

Contact: Dr. Thomas Ungar, Department of Psychiatry, North York General Hospital
4001 Leslie Street, 8th floor, North York, ON M2K 1E1
Tel: (416) 756-6655 Fax: (416) 756-6671 e-mail: tungar@nygh.on.ca

Counselling and Psychotherapy in Family Medicine - A Five Weekend Program

Sponsoring Organizations: Working with Families Institute
Department of Family and Community Medicine, Faculty of Medicine, University of Toronto

Starting Date: September 2001 (to June 2002) (next session)

Goals: To provide an intensive introductory course on current approaches and techniques to help family physicians increase their knowledge and clinical skills in office counselling and psychotherapy;

To enhance participants' ability to work with psychosocial issues and the patient-doctor relationship.

Description: This is the third year of the program. 16 physicians have been enrolled each year. The target audience for this year-long program is practising family physicians with an interest in dealing with psychosocial issues in family medicine.

Entry level concepts and skills will encourage physicians who are starting to include counselling/psychotherapy into their practice. Those more experienced will increase their level of competence and confidence by examining their own learning needs and developing strategies to strengthen and reinforce their own expertise.

The emphasis is on active participation, including "hands-on" practice and mentoring with skilled clinicians. The course consists mostly of practice-based small-group learning, including workshops by experts in the field, discussion of participants' therapy with their patients, live demonstrations of techniques and practical ways of integrating psychotherapy and counselling into general practice. Topics include sexual dysfunction, working with couples, working with families, grief counselling, addictions, brief treatment models, time-limited counselling, treatment of depression (drug/non-drug), working with challenging patients, family violence, psychopharmacology, palliative care, biopsychosocial aspects of medical illness, practical assessment skills and relaxation skills for stress management.

The course has been accredited for MAINPRO-M1 and MAINPRO-C credits. Faculty is drawn from the Department of Family and Community Medicine and other experts in the field.

Key Findings: Measurements of confidence and competence in providing psychotherapy improved during the course and for six months after its completion. Participants reported that they learned a lot from each other. Two mentoring sessions between each of the five weekends of the course proved to be very useful.

Contact: Dr. Mel Borins, Program Coordinator
Department of Family and Community Medicine
620 University Avenue, Suite 801, Toronto, ON M5G 2C1
Tel: (416) 533-6488 Fax: (416) 533-9204 e-mail: snirob@total.net

McMaster Muskoka Seminar Series

Sponsoring Organizations: Faculty of Health Sciences, Department of Psychiatry, McMaster University
St. Joseph's Healthcare, Hamilton

Starting Date: 1996

Rationale: The McMaster Muskoka Seminars were designed to provide clinicians with the opportunity to combine a relaxing summer holiday with continuing medical education.

Goals: To provide up-to-date information on an increasing variety of topics each year;

To be an ongoing source of quality continuing medical education;

To maintain a small group format to encourage discussion and interaction, while the number of attendees and topics offered increases.

Description: The McMaster Muskoka Seminars are a series of week-long seminars held in the Muskoka Region each summer, two of which are aimed at family physicians. They are designed to provide clinicians (family doctors, psychiatrists, mental health professionals) with current and topical information on a variety of mental health care topics. Education is based around clinical problems in small (up to 20 participants) groups. Topics covered include mood and anxiety disorders, psychotic disorders, assessing risk, problems of the elderly, attention deficit disorder, alcohol dependency, sleep disorders and medico-legal aspects of practice. The seminars have been approved for MAINPRO-C credits by the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons.

Key Findings: The seminars have been extremely well received by participants who acquired skills and knowledge to improve their patient management.

Lessons Learned: The Series has generally received excellent reviews from participants. Not only do they often return, they also spread the word to colleagues about the Series. This kind of word-of-mouth advertising is invaluable.

Difficulties Encountered: Providing affordable, quality CME, with top-notch faculty in a small group setting, while maintaining independence, is difficult financially. Financial support has been solicited from St. Joseph's Healthcare, and sponsorship of the event has been provided through small grants from various drug companies. The sponsorship and donations are used mainly to offset the costs of advertising and administrative fees; tuition fees are kept reasonable and cover the costs of providing quality faculty presenting up-to-date information.

Contact: Dr. Gary Chaimowitz, Forensic Unit
St. Joseph's Healthcare, Centre for Mountain Health Services
100 West 5th Street, P.O. Box 585, Hamilton, ON L8N 3K7
Tel: (905) 522-1155 ext. 5424 Fax: (905) 381-5606
e-mail: chaimow@mcmaster.ca
Website: www.mcmastermuskokacme.com

Diagnosis and Management of Common Mental Disorders in Primary Care

Sponsoring Organization: World Health Organization, Pan-American Health Organization

Funding: Health Canada
Ontario Ministry of Health
New Brunswick Ministry of Health
Alberta Mental Health Board
Quebec Ministry of Health

Starting Date: 1999 in Ontario (terminating March 2001)
1999 in New Brunswick (terminating June 2001)
Scheduled to begin in Alberta in October 200l and in Quebec in October 2001

Rationale: Research shows that 24% of patients who present themselves to primary care physicians suffer from a well-defined ICD 10 mental disorder and a further 9% suffer from a subthreshold disorder. These figures can be even higher with teenagers and the elderly. The majority of these patients (69%) present themselves to their physician with a physical symptom. Studies indicate that lack of time, knowledge and skills, as well as negative attitudes, prevent many primary care physicians from detecting and treating their patients' mental disorders. The educational package developed by the World Health Organization Department of Mental Health and Programme on Substance Abuse (WHO DMHPSA) in 1997 responded to a paucity of educational materials designed to assist primary care physicians in the diagnosis and management of common mental disorders.

Goals: To assist primary care physicians with diagnosis, treatment and management of the six most common mental disorders by improving their knowledge, skills and behaviours;

To facilitate early diagnosis, intervention and treatment of common mental disorders in the primary care setting;

To help patients and their families develop insight into mental disorders;

To teach patients how to monitor their symptoms and handle difficult situations;

To fill the gap created by inadequate undergraduate and post-graduate teaching about common mental disorders;

To encourage an effective relationship and increase the communication between the primary care physician and specialist (psychiatrist);

To increase the communication between the primary care physician and other available clinical resources (nursing, social work, occupational therapy, psychologist, etc.).

Description: The educational materials contain two diagnostic tools, followed by information modules on six common mental disorders: depression disorders, anxiety disorders, alcohol use disorders, insomnia, chronic fatigue and somatoform disorders. Each module has three sections. The first section, "doctor and patient handycard" is designed for psychoeducation. The second section, "patient leaflets" provides information to patients and their families. The third section consists of a questionnaire to be completed by the patient and returned to the primary care physician. The WHO materials were endorsed by the College of Family Physicians of Canada late in 1998 and translated into French early in 1999.

Three workshops were conducted for primary care physicians in Ottawa, Windsor and Brampton, Ontario, all in English. Workshops were held in Fredericton (in English) and in Moncton (in French) in February 2001.

The steering committee received funding from the Pan-American Health Organization to revise the materials and translate them into Spanish and Portuguese. This was expected to begin in May 2001.

Key Findings: There was a 60-70% attendance rate at the three Ontario workshops. Data are currently being collected from the pre-test and post-test questionnaires for analysis. The same evaluation process will be utilized for all provinces.

Lessons Learned: Overall, the implementation of this project has been a valuable experience.

Workshop evaluations indicated that physicians were eager to learn more about shared care, and that the topic was one of the attractions to the workshop. As well, interesting subjects, well-known speakers and CME points being offered, proved to be more important factors in encouraging attendance than the food and venue. Shared care is discussed at the end of each workshop.

Difficulties Encountered: Working with a very limited budget presented the greatest challenge. Organizing focus groups with primary care physicians before the workshops was also challenging. The Planning Committee was acutely aware of the time constraints on the primary care physicians, and strove to make workshops attractive to encourage attendance. Focus groups indicated that good food and a nice venue were essential for high attendance, however due to budget restraints, it was not possible to meet these requirements. In spite of modest food and venue, however, the attendance was higher than expected.

Contact: Dr. Fatos Baudouin, 34 Lakeside Avenue, Ottawa, ON K1S 3H2
Tel: (613) 237-9993 Fax: (613) 237-9993 e-mail: baudouin@attglobal.net

Guidelines for the Diagnosis and Pharmacological Treatment of Depression

Sponsoring Organization:	Canadian Network for Mood and Anxiety Treatments (CANMAT)
Funding:	Ontario Ministry of Health and Long-Term Care
Resources:	Psychiatrists, family physicians and pharmacists participated in the program.
Starting Date:	1997
Rationale:	The project arose from the results of the Ontario Health Survey, Mental Health Supplement.
Goals:	To demonstrate underdetection and undertreatment of depression; To enhance physician awareness of mood and anxiety disorders and their treatments.
Description:	A guide to the treatment of depression was produced, and a series of educational workshops organised across Canada to introduce the guide. The first section of the guide focuses on the assessment of depression, including key symptoms, a diagnostic decision tree and common general medical conditions and medications that can also cause depression. It also identifies risk factors for suicide and outlying treatment of principles. Section two focuses on the pharmacological treatment of depression with a comprehensive list of drug approaches to major depression, “anxious” depression, atypical depression, and seasonal affective disorders, melancholic depression, and psychotic depression. Section three summarizes the treatment of other depressive disorders including dysthymia, bereavement, adjustment disorder, mixed anxiety/depression, minor depression and premenstrual dysphoria. The fourth section looks at depression in specific populations examining the influence of gender (postpartum and peri- and post-menopausal issues), age, developmental disability, and medical illness. The final section addresses specific psychopharmacological issues such as optimizing patient adherence, the non-responder, and discontinuing antidepressants. Implementation projects involved “Mood Fair” - a two-day educational event for family physicians and psychiatrists developed by CANMAT and presented in Toronto, Montreal, Vancouver and Halifax to 600 physicians, with multiple sponsors.
Key Findings:	Plenary sessions and workshops were designed in response to needs assessment. Most sessions were well rated, but significant differences in levels of satisfaction were observed across Canada for different aspects of the program.
Difficulty Encountered:	The production of educational materials required a major investment of time.
Implications:	New clinical practice guidelines for psychiatrists have been developed. New implementation strategies will be developed.
Contact:	Dr. Sidney H. Kennedy, Psychiatrist in Chief University Health Network - Toronto General Site 8th Floor, Eaton Wing, Room 222, 200 Elizabeth Street, Toronto, ON M5G 2C4 Tel: (416) 340-3888 Fax: (416) 340-4198 e-mail: sidney.kennedy@uhn.on.ca

Ontario Guidelines for the Management of Anxiety Disorders in Primary Care

Sponsoring Organizations: Ontario Program for Optimal Therapeutics (OPOT)
Department of Family and Community Medicine, University of Toronto

Funding: Ontario Ministry of Health and Long-Term Care

Starting Date: 2000

Rationale: There is increasing recognition of the high prevalence of anxiety disorders in primary care. There is a need to provide family physicians with relevant approaches to treatment for this diverse group of disorders that are not always easy to classify. The challenge for family physicians is to be able to identify individuals with anxiety disorders, be familiar with treatment and select appropriate therapy.

Goal: To develop guidelines for the detection and treatment of anxiety disorders in primary care settings.

Description: The guide evaluates the effectiveness of treatment according to three levels of evidence:

I. Good research-based evidence

II. Fair research-based evidence

III. Expert clinician opinion.

For each of the major anxiety disorders, the guide outlines specific questions to ask to differentiate symptoms and come up with a diagnosis as well as risk factors and differential diagnoses. It then outlines comprehensive treatment plans that include psychoeducation, lifestyle change and non-pharmacological strategies, community resources and supportive counselling, self-management strategies, pharmacotherapy and cognitive behavioural therapy. It also offers therapeutic tips to assist with management.

The appendices include “red flags” for detection, a diagnostic flow chart, glossary for CBT, DSM-IV criteria for anxiety disorders, further details on pharmacotherapeutic agents, consumer and self-help reading lists, educational resources and references.

Key Findings: To date, the guide has been well received by family physicians, residents, and psychiatrists and is being broadly circulated.

Lessons Learned: Well-prepared guidelines can assist family physicians in detecting and managing anxiety disorders in their patients.

Contact: Dr. Mike Evans
University Health Network - Toronto Western Site
West Wing, 2nd floor, 399 Bathurst Street, Toronto, ON M5T 2S8
Tel: (416) 603-5888 e-mail: michael.evans@utoronto.ca

DIRECT (Depression & Anxiety Information Resource & Education Centre Toll-Free) Program

Sponsoring Organizations: Ontario Ministry of Health and Long-Term Care
Hamilton Psychiatric Hospital and St. Joseph's Hospital, Hamilton
McMaster University, Department of Psychiatry and Behavioural Neurosciences
Bristol-Myers Squibb Pharmaceutical Group
Eli Lilly Canada
SmithKline Beecham Pharma Canada
Wyeth-Ayerst Canada
Pfizer Canada

Starting Date: 1996

Rationale: Mental health agencies and health care professionals have increasingly been called upon to provide expert advice and appropriate treatment options for people with mood and/or anxiety disorders. At the same time, information about these disorders and effective treatment choices is expanding. DIRECT was created to promote awareness of and to provide accessible expert medical information about mood and anxiety disorders to individuals, family members, family physicians and other health care workers, and the community as a whole.

Goals: To reduce the stigma associated with mental illness by providing information to the public that depression and anxiety are illnesses which are common and treatable;

To encourage individuals suffering from a mood and/or anxiety disorder, regardless of their age, ethnicity or complexity of problem, to seek appropriate help from their physicians and allied health care professionals;

To promote more effective, humane and satisfactory treatment for individuals with mood and/or anxiety disorders;

To improve the rate of early, accurate diagnosis and effective treatment for people with mood and anxiety disorders.

Description: DIRECT is a McMaster University, Faculty of Health Sciences program which provides four core services:

(1) producing and distributing information about mood and anxiety disorders to help individuals recognize and seek treatment for illness;
(2) conducting research about the effective treatment of mood and anxiety disorders;
(3) maintaining inventories of resources and references; and
(4) participating in educational activities that encourage learning about the effective treatment of mood and anxiety disorders.

Information available through DIRECT has been written, reviewed and recorded by Canada's foremost experts in depression, manic depression and anxiety. Service is delivered via a website (http://www.mcmaster.ca/direct) and toll-free telephone lines accessible across Canada. Both the website and toll-free line have designated physician and consumer/public sections. The program also distributes educational kits about mood and anxiety disorders and about the DIRECT program free of charge across Canada.

Key Findings: There is a definite need for accurate expert-based information. After six years, the program still averages 370 calls per month.

Contact: Gayle Stoness, Program Manager
DIRECT Education & Information Resource Centre
Department of Psychiatry and Behavioural Neurosciences
McMaster University, 1280 Main Street West, Hamilton, ON L8S 4K1
Tel: (905) 522-1155, ext. 5512 e-mail: direct@mcmaster.ca

ACCESS: A National Program of Education and Consultation in Psychiatry

Sponsoring Organization: Janssen-Ortho Inc.

Starting Date: 1997

Rationale: Primary care physicians play a major role in the delivery of mental health care, particularly in communities without psychiatric consultants. The academic literature highlights underdiagnosis and undertreatment of a variety of psychiatric problems by family physicians. This program was developed as a continuing education program, making use of the most current educational technologies of small group, problem-based interactive learning, to assist family physicians to gain knowledge and skills about management of psychosis. It was hoped that this program could assist in improving the knowledge gap of family physicians, thereby improving the treatment of patients with psychosis in Canada.

Goal: To evaluate improvement in family physicians' knowledge following a clinically-relevant psychiatric continuing education program.

Description: Research on the differences between psychiatric and family physician practice settings suggests that attention to contextual features is important to overcoming problems of knowledge transfer from specialists to generalists during CE activities. ACCESS is a national CE program in schizophrenia and related psychotic disorders that attempts to maximize contextual relevance for family physician participants using two longitudinal case-based workshops in the family physicians' local communities.

Approximately 100 psychiatrists from across Canada who had received one day of faculty development training acted as facilitators/mentors for these workshops. In addition, learners were each allowed three telephone calls to their psychiatrist/mentor when specific problems arose in their family practice. The program ran from 1997 to 1999 with over 1500 family practice registrants from across Canada.

A random sample of learners completed pre- and/or post-MCQ's to evaluate changes in knowledge. To maintain anonymity, it was necessary to use between subjects' comparisons of the scores. In addition, facilitators were surveyed for the frequency and use of the telephone consultations.

Key Findings: Participants showed significantly higher post-test scores (88.21% + 1.01) than pre-test scores (76.18% + 1.43) on the MCQ [$t(25)=4.26$, $p<.01$]. The telephone contacts were rarely if ever used.

Lessons Learned: Significant improvement in family practice learner knowledge was achieved through the use of this clinically-relevant CE program. However, contrary to predictions of adult education theory, learners made little use of the opportunity for office-based consultation through the telephone mentoring option.

Implications: This program was successfully implemented and well received. Improvement in learners' knowledge was demonstrated. To be successful on a national scale, this program required training of the psychiatric facilitators, development of a wide variety of program materials, and a large budget for its implementation. Surprisingly, the phone consultation aspect of the program was not successful. It is believed that was because the phone consultations were not linked to clinical cases due to medical/legal concerns. An attempt to make the phone consultations only educational in nature was unsuccessful.

Contact: Dr. Thomas Ungar, Department of Psychiatry, North York General Hospital
4001 Leslie Street, 8th floor, North York, ON M2K 1E1
Tel: (416) 756-6655 Fax: (416) 756-6671 e-mail: tungar@nygh.on.ca

Pocket Psychiatry Reference Cards

Sponsoring Organizations: Indirectly sponsored through support from undergraduate and postgraduate medical programs, as well as academic bookstores.

Starting Date: September 1999

Rationale: An exhaustive search of the medical and psychiatric literature was conducted. Many of the resources currently available provide inaccurate information, unsupported by scientific data. Many inconsistencies were found in the published literature. A need was identified for accurate, distilled, unbiased reference cards to aid practitioners in the delivery of mental health care.

Goals: To provide current, accurate, evidence-based and unbiased effective learning resources for health care professionals, including family physicians, resident trainees, psychiatrists, emergency medicine specialists, nurses, medical students, mental health care providers and other student learners;

To display the information in easy-to-use, quick reference guides that are readily transportable and usable in the clinical setting;

To improve patient care through the use of new instructional technologies and curriculum development initiatives;

To work in conjunction with primary care and specialty mental health care providers to develop quality learning tools for neuropsychiatry that best fit their needs.

Description: Thus far, three pocket medical reference cards have been published and distributed. The Neuropsychiatry Exam Card is focused on clinical assessment in both neurology and psychiatry. The Psychiatry Drug-Related Emergencies Guide contains key information for the diagnosis and management of common and life-threatening toxidromes related to drugs of abuse and psychotropic medications. The Psychopharmacology Guide summarizes important clinical information regarding the use of all the major classes of psychotropic medications.

Lessons Learned: Additional feedback from family physicians has suggested the need for a case-based, algorithmic approach to psychiatric assessment, diagnosis and treatment.

Difficulty Encountered: Trying to keep the reference cards pocket-sized while including all of the necessary content and making the print large enough to be easily read has been challenging. Alternative formats such as posters, small booklets or software content for palm-sized computers may help with this issue.

Contact: Dr. Anthony Levinson
Tel:(905) 521-2100 ext. 76428 Fax: (905) 527-5009
e-mail: levinsa@mcmaster.ca
neuropsychiatry@sympatico.ca
website: www.neuropsychiatry.ca

Stepped Care Module for Depression Management

Sponsoring Organization: Mental Health Evaluation and Community Consultation Unit (MHECCU), UBC

Starting Date: Stepped Care tools have been developed and field-tested. These tools will be available at no or minimal cost by May 2002.

Goals: To provide primary care physicians and mental health workers with tools to manage depressed individuals more effectively using a CBT model;

To increase the knowledge of depressed individuals about their disorder, and to provide patients with practical and evidence-based techniques that can be used to manage depression more effectively.

Description: There are four components to the module:

(1) The Self-Care Patient Guide (50 pages) gives patients a comprehensive biopsychosocial model of depression, explains how it can be effectively managed according to the available research, and gives a step-by-step guide to changing patterns that trigger depression. It can be downloaded at no cost from a website;

(2) A single-sheet Depression Handout for distribution to depressed patients in primary care gives a brief biopsychosocial model of depression and evidence-based change strategies. It can be downloaded at no cost from a website;

(3) A Provider Manual gives background information and guidelines for coaching patients in application of the self-care depression change strategies;

(4) A manualized group CBT treatment for depression (Changeways) that can be easily implemented in mental health centres or outpatient programs.

Development of these stepped care tools has involved ongoing feedback from family physicians, other providers and patients as to the feasibility and acceptability of the content and presentation. The Self-Care program has been field-tested by a sample of family practitioners with highly rated acceptability and utility. The Changeways program has been extensively implemented and has received high acceptability and utility ratings from providers and patients.

Contacts: Dr. Dan Bilsker, Psychiatric Assessment Unit, JPPN-G, Vancouver Hospital,
855 W. 12th Avenue, Vancouver, BC V5Z 1M9
Tel: (604) 875-5256 Fax: (604) 875-4226 e-mail: dbilsker@interchg.ubc.ca

Dr. Randy Paterson, Changeways Program, Department of Psychology,
UBC Hospital, 2211 Wesbrook Mall, Vancouver, BC V6T 2B5

Depression Education in Primary Care

Sponsoring Organization:	Hamilton HSO Mental Health & Nutrition Program
Funding:	Hamilton HSO Mental Health & Nutrition Program
Starting Date:	1998
Rationale:	The most common psychiatric illness seen by the family physician in primary care is depression. Much of the scientific literature to date suggests that a multifaceted approach to educating family physicians and patients about depression will lead to improved health care outcomes and enhance patient satisfaction. However, relevant and appropriate depression education materials for patients in primary care have been lacking.
Goals:	To develop a manual to be utilized by family physicians and mental health counsellors in primary care to educate patients and their families about depression; To promote early patient symptom recognition, resulting in early and appropriate treatment; To promote adherence to medication treatment (to avoid possible relapse); To improve the cost effectiveness of treatment of major depressive disorder; To strengthen the patient-physician relationship in primary care.
Description:	Staff from the HSO Mental Health & Nutrition Program developed a depression education manual, consisting of a number of sections including diagnosis, treatment modalities and community resources. Two half-day workshops were held in the spring of 2000 for 32 counsellors and family physicians, training them to facilitate depression education sessions in their primary care setting. The workshops were evaluated by the participants and accredited by the Ontario College of Social Workers, the Ontario College of Family Physicians and the Ontario Nurses' Association. To date, 30 sessions have been held for patients and their families, with material presented in one 3-hour session or as deemed appropriate by the facilitators. Each session is evaluated by the participants. Since its inception, approximately 500 people have participated in the program.
Key Findings:	The program has been well received by physicians, counsellors, patients and their families and friends.
Difficulties Encountered:	Ensuring the materials used are relevant to the needs of primary care patients has been challenging. Many family physicians do not feel they have sufficient time to run such groups, leaving it to the counsellors.
Contact:	Anne Marie Crustolo, Coordinator, HSO Mental Health & Nutrition Program 40 Forest Avenue, 2nd Floor, Hamilton, ON L8N 1X1 Tel: (905) 521-6133 Fax: (905) 521-6107 e-mail: acrustol@mcmaster.ca
Reference:	Depression Education Panel. Depression in Primary Care. Clinical Practice Guideline, Number 5, Rockville MD US Department of Health & Human Services, Public Health Service, Agency for Health Care Policy and Research.

Research

As the move towards greater collaboration gathers pace, the development of new projects needs to be guided by evidence from other projects and the lessons that can be learnt from these. A major asset in this regard will be the comprehensive literature review completed by members of the Collaborative Working Group, and recently published as a supplement to the Canadian Journal of Psychiatry.

To build on our current knowledge as to what makes for a successful collaboration and its potential benefits, it is important that new projects are evaluated. These findings can then be shared with, and help, colleagues who are already involved in similar activities or who are planning new projects.

To date, however, there have not been many Canadian studies in shared care. It is not surprising, therefore, that one area of investigation has been focus groups asking family physicians about their management of patients with mental health problems and changes they might like to see in their relationships with mental health services. These studies also raise important questions for further investigation.

Other research studies have covered a variety of projects and methodologies including needs assessment surveys, evaluation of current projects, studies assessing the prevalence or management of specific problems in primary care, and the evaluation of particular educational tools for family physicians. The focus of some of these projects has been the evaluation of the impact of enhanced collaboration, particularly of initiatives aimed at increasing access to mental health services or improving communication between providers from different backgrounds.

In the longer term, one of the goals of the CPA/CFPC Working Group is to bring together colleagues with an interest in research in shared mental health care to develop a national research strategy. The hope is that this will identify key questions for future projects, each of which could in turn become a focus for collaborative research by investigators in different regions of Canada.

Shared Care Literature Review and Bibliography

Goals:

This review was prepared to support the work of the Collaborative Working Group on Shared Mental Health Care, and in response to requests from health planners, policy makers, administrators, researchers and educators for a comprehensive overview of the current status of shared mental health care.

Description:

Computerized databases from 1985 - 2000 were searched for articles addressing linkages between mental health and primary care services. Additional references were sought based on the lists of references in these articles. Major themes and topics were identified and articles were then sorted by consensus into the various topics. These included models of clinical collaboration, care of the mentally ill, residency training, continuing education, evaluation and research.

An overview was written for each topic, accompanied by the relevant references. Information was more complete and comprehensive on some topics than on others. For some topics, suggestions were made for future directions, and for filling the gaps in knowledge. Publication as a Canadian Journal of Psychiatry supplement will facilitate distribution and ensure wide availability.

Key Findings:

Despite many reports, there is no great consistency in what and how results are reported. Too many papers lack an adequate description of the program and its context to readily generalize results to other settings. There is a need for more detailed descriptions, and for more standardized evaluation methodology. The review serves to highlight the topics covered by the shared care rubric, focus on the issues in each area, and offer suggestions for further development.

Contact:

Dr. Marilyn Craven, Community Psychiatry Services, St. Joseph's Hospital,
Charlton Site, Fontbonne Building, 3rd floor, Hamilton, ON L8N 4A6
Tel: (905) 522-1155 ext. 4069 Fax: (905) 521-6059
e-mail: cravenm@mcmaster.ca

Secondary Analysis of the Ontario Mental Health Survey with Respect to Shared Mental Health Care

Sponsoring Organization: Clarke Institute of Psychiatry

Starting Date: 1990 - published 1997

Goal: To determine family physicians' role in the mental health care system in Canada.

Description: The Mental Health Supplement to the Ontario Health Survey is an epidemiological, retrospective, home-interview survey of 9953 Ontario residents, conducted in 1990 and 1991. Results reported are based on responses of a weighted sample of patients aged 15 to 64. A standardized assessment of mental disorders, associated risk factors and disability, and patterns of use of mental health services was conducted.

Key Findings: More people seek mental health services from their family physicians than from psychiatrists, social workers or psychologists. Among patients who consulted for mental health purposes, more than 35.4% saw family physicians only, 24.7% saw family physicians and other mental health care providers (psychiatrists, psychologists, social workers, others), and 40% saw other mental health care providers only. There were few sociodemographic, diagnostic, or clinical severity differences between the family physician-only group and the other two groups. Some evidence suggested family physicians saw more recent onset cases, but they were also involved in joint care for more complex or disabled cases. More than 57% of those seeing family physicians received medication; 43% received other forms of care. Those seeing family physicians only made four visits per year; those who consulted other mental health professionals made 14 to 20.

Lessons Learned: The study confirms the important role family physicians play in the current system of health care delivery in Canada. This role should be further investigated, taking into consideration family physicians' obvious contributions, rather than having planners or specialists view them as backups in the absence of enough specialists. One important example is the finding that patients seeing their family physicians for mental health reasons report that their family physicians provide more than medication, an unacknowledged aspect of their work. Specialized services need to improve links with family and general practitioners so that referral and the provision of joint care are more rational.

Difficulty Encountered: The implementation of such a large-scale study requires survey experts like Statistics Canada.

Contact: Dr. Alain Lesage, Centre Fernand-Seguin
7331 rue Hochelaga, Montreal, QC H1N 3V2
Tel: (514) 251-4015 ext. 2365 Fax: (514) 251-5404
e-mail: alesage@ssss.gouv.qc.ca

References: Parikh SV, Lin E, Lesage AD. Mental Health Treatment in Ontario: Selected Comparisons Between the Primary Care and Specialty Sectors. Canadian Journal of Psychiatry 1997; 42:929-934.

Lesage AD, Goering P, Lin E. Family Physicians and the Mental Health System: A Report from the Mental Health Supplement to the Ontario Health Survey. Canadian Family Physician 1997; 43:251-256.

Mental Health Care in the Primary Care Setting

Sponsoring Organization:	Health Services Utilization and Research Commission (HSURC) of Saskatchewan
Funding:	HSURC (no external funding)
Starting Date:	January 2002
Rationale:	There are twenty "primary health sites" in the province, of which the defining feature is a primary care nurse on staff (and most general practitioners at these sites are paid by salary). Many sites also have an on-site mental health worker or a mental health worker who visits the site on a regular basis. Saskatchewan also has five community clinics, which are multidisciplinary and offer a range of services, including mental health services, on site. Saskatchewan Health recently announced an action plan for health reform, which includes recommendations to promote and expand primary health teams and primary health networks. All of these initiatives indicate an interest in and support for shared care, yet few of these initiatives have yet been evaluated, nor have potential barriers and solutions to best practices in shared care been explored in the province. This project will help fill these gaps.
Goals:	To identify best practices in shared mental health care; To identify current practices in Saskatchewan in terms of how mental health issues are addressed in the primary care setting, i.e., family physician practices; To identify how variability in current practices affects outcomes of individuals with mental health problems; To identify barriers and solutions to best practices in general, and in Saskatchewan in particular.
Description:	A systematic literature review will be conducted to identify best practices in shared mental health care. A survey will be administered to all family physicians in Saskatchewan. Their responses will be linked to secondary data, e.g., hospitalization data from Saskatchewan Health, outcomes data from the National Population Health Survey or Canadian Community Health Survey. Focus groups will be held with key individuals.
Difficulty Encountered:	The original research design included a prospective observational study of patients in family physician practices. However, due to difficulties recruiting physicians to participate in similar past and current HSURC studies, it was decided that secondary data would be used instead.
Contact:	Heather MacDonald, Research Officer Health Services Utilization and Research Commission (HSURC) Box 46, 103 Hospital Drive, Saskatoon, SK S7N 0W8 Tel: (306) 655-6641 Fax: (306) 655-1462 e-mail: macdonaldh@hsurc.sk.ca

How Can General Practitioners and Psychiatrists Cooperate Most Profitably with Each Other at the Primary Care Level? An Exploratory Research Project in Eastern Montreal

Sponsoring Organizations: Centre de Recheche Fernand-Seguin
Hôpital Louis-H. Lafontaine
Régie Régionale de Montréal Centre
College des Médecins du Québec
Ministry of Education (CAPES) BRAZIL

Starting Date: Spring 1998

Goals: Qualitative Arm:

To understand how general practitioners and psychiatrists can cooperate most profitably with each other at the primary care level.

Quantitative Arm:

To collect the opinions of psychiatrists and general practitioners in eastern Montreal with respect to strategies for improving collaboration between these two groups of physicians;

To outline the profile of psychiatrists and general practitioners who are most inclined to collaborate in their medical practices.

Description: The qualitative arm of the study consisted of ten in-depth interviews and one focus group session.

The quantitative arm will consist of a questionnaire and a survey.

Key Findings: In order to identify psychiatrists and general practitioners interested in sharing psychiatric patient care in a primary care setting, study participants outlined some characteristics of general practitioners and psychiatrists who are generally interested in collaboration.

Participants' responses indicated that GPs interested in collaboration are generally younger, have completed a residency program in family medicine, work at least part-time in a CLSC, are paid by salary or by a mixed mode of remuneration (fee-for-service and salary), participate in continuing medical education activities on mental health topics and are committed to providing their patients, including patients with psychiatric problems, with long-term follow-up.

Psychiatrists interested in collaboration are generally involved with teaching family medicine residents in primary care settings and approach their patients through active discourse, rather than passive listening.

Participants were also surveyed concerning strategies of communication (which means of communication is most effective, how can communication be improved, what content is most useful in the general practitioner's consultation request and in the psychiatrist's answer); strategies of continuing medical education (how should programs be organized, the importance of continuing medical education in enabling general practitioners to manage their patients more skilfully); and strategies of access to psychiatric consultation (which models of collaborative care are most effective).

Lessons Learned: Shared care principles are accepted by some but not all physicians (general practitioners and psychiatrists). Shared care practices can vary substantially from one environment to another (Ontario compared with Quebec).

Difficulties Encountered: There was less-than-ideal collaboration between general practitioners and psychiatrists, especially in one hospital catchment area (which is in the process of

transferring psychiatric care from a hospital basis to community settings). Because ensuring physician participation in a study can sometimes be difficult due mainly to time constraints, the following strategies were adopted: 1) physician participation was designed to be as short as possible; 2) physicians were always contacted first by key people (members of medical associations, academics, etc.); 3) a meal was always offered in meeting with physicians (for instance, focus groups and pretest of the questionnaire); and 4) in the study budget, a certain amount of money was assigned to financial incentives for physician participation (for instance, $20 gift certificates for books or for donations).

Implications:

The results of the study reflect physicians' opinions on how to improve collaboration between general practitioners and psychiatrists. This information may contribute to the process of designing services which are compatible with providers' (especially physicians') expectations as well as with the demands of their practices.

Shared care may be the beginning of a much-needed update in medical practice to enable physicians (and other professionals) to meet the increasingly complex demands of caring for their patients.

Contacts:

Dr. Ricardo J. M Lucena
Centre de Recheche Fernand-Seguin (Unite 218), Hôpital Louis-H. Lafontaine
7331 rue Hochelaga, Montréal, QC H1N 3V2
Tel: (514) 251-4015, ext. 3503 Fax: (514) 844-8545 or 251-5404
e-mail: lucenar@videotron.ca

Dr. Alain Lesage, Centre Fernand-Seguin
7331 rue Hochelaga, Montréal, QC H1N 3V2
Tel: (514) 251-4015 ext. 2365 Fax: (514) 251-5404
e-mail: alesage@ssss.gouv.qc.ca

Collaborative Consultation Relationships - Academic Study

Starting Date:	1998
Rationale:	This study attempted to further articulate the nature of collaborative consultation relationships. Rather than describing collaboration between psychiatry and family medicine, this study sought to describe exactly what is required for collaborative relationships to develop and be maintained.
Goal:	To attempt to describe the specific qualities required for establishing collaborative consultation relationships between psychiatry and family practice in order to better inform the shared care model.
Description:	The study examined an innovative service delivery program between psychiatry and primary care at North York General Hospital in North York, Ontario, comparing and contrasting it with traditional consultation models.
Key Findings:	Three factors enabled better consultation relationships: the consulting physician's stance, cultural competence - striving to understand the culture and context of the primary care physician, and the capacity to develop an integrative systemic view when working in a primary care setting.
Difficulty Encountered:	The main difficulty in the study was the lack of medical literature addressing the topic of collaboration within the medical consultation relationship. As a result, the literature search and academic approach were broadened to include relational theory, business management, education, anthropology and sociology.
Implications:	Shared care is primarily a process which will only work if truly collaborative relationships are fostered and maintained. This goes well beyond the geographics of sharing patient care. Professional development focusing on collaborative working models will be required for all members working within shared mental health care if it is to achieve its promise as a service delivery model.
Contact:	Dr. Thomas Ungar, Department of Psychiatry, North York General Hospital, 4001 Leslie Street, 8th Floor, North York, ON M2K 1E1 Tel: (416) 756-6655 Fax: (416) 756-6671 e-mail: tungar@nygh.on.ca
Reference:	Ungar TE, Jarmain S. Shared Mental Healthcare: A Collaborative Consultation Relationship. Hospital Quarterly Winter 1999/2000; 3(2):34-40.

Survey of Family Physicians' Needs in Handling Psychiatric Crises

Sponsoring Organizations: Centre for Studies in Family Medicine, University of Western Ontario
Department of Psychiatry, University of Western Ontario

Starting Date: 1998

Goals: To determine service gaps and clinical needs experienced by family physicians in handling psychiatric crises;

To explore possible collaborative service models;

To determine the resulting educational needs of family physicians.

Description: The study consisted of three components: focus groups with family physicians, key informant interviews, and a survey mailed to family physicians in six southwestern Ontario counties. The survey dealt with two types of psychiatric crises: less urgent and emergency. The overall survey response rate was 57.4%.

Key Findings: Counties with less favourable population per non-specialist physician ratios tended to have lower overall satisfaction ratings. The population per active psychiatrist was not correlated with satisfaction.

The availability of support and the degree of helpfulness in dealing with emergency psychiatric crises were key components of family physicians' satisfaction with these services. Assessment by telephone consultation with a psychiatrist, central triage, and a crisis and brief treatment service (based in the psychiatric hospital located in one county) were considered much more helpful services than the hospital Emergency Room and other hospital-based services.

The number of hours spent on crisis work was not correlated with overall satisfaction with crisis services. An urgent need to examine the causes for delays in arranging assessments for patients was identified.

In general, family physicians were moderately satisfied with communication and feedback by psychiatrists and other professionals, with feedback on the telephone being favoured. Promptness was ranked lower than respect and understanding.

Emergency services for children, adolescents and transitional youth were generally less available than those for adults, related, perhaps, to a shortage of child psychiatrists. Emergency services for patients presenting with psychoses, affective disorders, suicide and violence were moderately accessible, which may be a result of "restructuring" with its emphasis on care of the seriously mentally ill. The most common concern leading to referral to ER crisis services was suicide/homicide potential and a perceived need for inpatient admission. Early community crisis treatment and a range of non-bed-based services may be an alternative to hospital-based services.

The collaborative care approach was favoured by the majority of respondents, provided roles were clearly defined. Specifically helpful were access to outpatient crisis intervention, telephone backup by local crisis teams, telephone consultation by psychiatrists and continued support from the multidisciplinary outpatient team after the initial consultation.

The preferred method of continuing education was through small groups, lectures, workshops and the consultation process itself, in order to improve the skills necessary for assessment of patients in crisis, pharmacological management, knowledge of community resources, etc.

Lessons Learned: Several features common to the two highest-rated (in terms of satisfaction) services were identified. These included triage, partnership with ER physicians, immediately

available clinical interventions and short-term follow-up, involvement of other professionals such as a nurse, psychologists and social workers along with psychiatrists, and a single governance of both crisis treatment/intervention and short-term follow-up.

Contact:

Dr. J. D. Mendonca , Director
Crisis and Relapse Prevention Service
Regional Mental Health Care St. Thomas
467 Sunset Drive, P.O. Box 2004 , St. Thomas, ON N5P 3V9
Tel: (519) 631-8510, Fax: (519) 631-2512

An Educational Needs Assessment for Urban and Rural Primary Care Clinicians in Eastern Ontario: Focus on Youth Mental Health

Funding:	Research Institute, Children's Hospital of Eastern Ontario
Resources:	Child and adolescent psychiatrist 1/2 day per week
Starting Date:	December 2000
Rationale:	Up to 40% of adolescents suffer from psychiatric disorders or psychological distress, however only one in ten children in need of treatment is receiving it. Due to the shortage of child and adolescent psychiatrists in Ontario, family physicians do not always have timely access to consultations. This needs assessment survey has been established in an attempt to understand the perceived needs of the community in child mental health, in preparation for setting up an eastern region child psychiatry collaborative project.
Goal:	The long-term goal is to assist child psychiatrists in Eastern Ontario to have a more informed view of what front-line clinicians wish and need to learn to enable them to provide the children and adolescents in their practice with timely, evidence-based mental health care.
Description:	In phase one, a randomly selected group of 50 rural and 50 urban family physicians and other front-line health care professionals who see children and adolescents will be surveyed with a view to looking at learning preferences and preferred format (e.g., lecture vs. seminar vs. live supervision). This phase of the project is nearing completion. Phase two will be to assess through survey or focus group unperceived learning needs in a similar group of clinicians.
Contact:	Dr. Helen R. Spenser, Children's Hospital of Eastern Ontario 401 Smyth Road, Ottawa, ON K1H 8L1 Tel: (613) 737-7600 Fax: (613) 737-2257 e-mail: spenser@cheo.on.ca

Family Physicians' Experiences in Caring for Patients with Serious Mental Illness

Funding: London Health Sciences Center internal research funds

Goal: To examine family physicians' experiences in caring for patients with serious mental illness and their expectations of a shared mental health care model.

Rationale: Across Canada, health care restructuring is underway and primary care reform is being actively promoted, resulting in many changes to the delivery of health care, particularly in the area of mental health care reform.

Description: In-depth semi-structured interviews were conducted with a purposive sample of eleven full-time family physicians in London, Ontario who provide ongoing care for seriously mentally ill patients. All interviews were audiotaped and transcribed verbatim. The analysis strategy used a constant imperative approach and occurred concurrently rather than sequentially. All interview transcriptions were read independently by the researchers, who then compared and combined their analyses. Final analysis involved examining all interviews collectively, thus permitting relationships between and among central themes to emerge.

Key Findings: The findings reflected three main themes: what family physicians perceive they bring to the care of the seriously mentally ill (i.e., a whole person approach to care), the challenges family physicians presently experience in participating in the shared care of these patients (i.e., communication and access issues), and family physicians' expectations of a shared mental health care model (i.e., guidance and feedback).

Lessons Learned: As de-institutionalization of seriously mentally ill patients rapidly proceeds, the need for an effective and efficient shared mental health care model becomes imperative. The study findings suggest that family physicians could be important partners in a shared mental health care model, but only if the systemic barriers are removed and collaborative practice encouraged.

Contact: Dr. Judith Belle Brown, Centre for Studies in Family Medicine,
100 Collip Circle, Suite 245, London, ON N6G 4X8
Tel: (519) 858-5028 Fax: (519) 858-5029 e-mail: jbbrown@uwo.ca

Reference: Brown J, Lent B, Stirling A, Takhar J, Bishop J. Family Physicians' Experience in Caring for Patients with Serious Mental Illness. Canadian Family Physician (in press).

Evaluating Satisfaction of Local Family Physicians with Mental Health Services in Hamilton

Sponsoring Organization: Hamilton HSO Mental Health & Nutrition Program.

Goal: To evaluate family physicians' satisfaction with local mental health services and to elicit their suggestions for improvements.

Description: A questionnaire was developed to assess the current level of satisfaction of family physicians with different mental health services (i.e., inpatient, outpatient, child, geriatric, emergency, etc.) using a five-point Likert scale and, where indicated, reasons for dissatisfaction. A section on possible improvements was also included. The survey was sent to all 290 family physicians in full- or part-time practice in Hamilton-Wentworth. Responses were subdivided according to physician and practice characteristics.

Key Findings: The response rate was 52%. The highest level of satisfaction (6.7) was found with having mental health services integrated within a family physician's practice. The lowest was with services for children and adolescents (3.6). For other services, satisfaction ratings were between 4.2 and 5.0.

Problems commonly identified included inconsistent intake policies, psychiatry being seen as more difficult to refer to than other specialties, long waiting lists, poor communication, a perceived lack of collaboration and the need for better counselling for couples and families.

Responding to a list of suggestions, family physicians identified the changes they would most like to see as having a list of psychiatrists in the community accepting cases, telephone access to psychiatric backup, visits by psychiatrists to their offices to see cases and standardised intake procedures.

Implications: Family physicians appreciate being involved in evaluating mental health services. The major changes they would like to see are to be better informed about available services, intake procedures that are briefer and more user- friendly, improved clinical communication and a more collaborative approach.

Contact: Dr. Nick Kates, 40 Forest Avenue, 2nd floor, Hamilton, ON L8N 1X1
Tel: (905) 521-6133 Fax: (905) 521-6107 e-mail: nkates@mcmaster.ca

Ontario Primary Mental Health Care Model Study

Goals:

To explore the barriers to optimal mental health care in the primary care setting;

To examine different clinical approaches to primary mental health care in Ontario in order to evaluate both the organizational and practical barriers to good care;

To look into the possibility of redesigning the current model of primary mental health care, and to understand the direction that such changes should take.

Description:

Focus groups of 5 - 7 family physicians and GP psychotherapists, all in group practices in Toronto and Hamilton, Ontario were selected to participate in the study. Standardized questions were used to obtain qualitative data. Participants were asked what they viewed as the principal barriers to optimal mental health care, how they coped with the existing system for mental health care in the primary care setting, and how they might envision a new model for primary mental health care. They were also asked if and how they could incorporate a primary care mental health toolkit into their individual practices. This would include drug therapy guidelines for depression and anxiety, patient screeners and assessment guides, clinician patient prompters, self-care homework and the Ontario Mental Health Resource Index. The sessions were taped, transcribed, and analyzed.

Key Findings:

The practical and professional complexity of providing mental health care in the primary care setting, and the lack of a model that accepts, promotes and facilitates good mental health care in this setting proved frustrating. The frequent overlap of physical and mental health problems presents problems with regard to billing, scheduling and treatment. It is also an area of care which requires a solid practical and academic knowledge base, and yet primary care physicians are limited in their access both to adequate training and to mental health care professionals.

Implications:

It is a reality of family medicine that good primary care must include good mental health care. Currently, primary care physicians manage to cope with the practical, professional and administrative challenges that characterize primary mental health care in Ontario. This study confirms the need for a new model of primary health care, one that advocates the role of the primary care physician among the working community of mental health care providers.

Contact:

Dr. Mike Evans
University Health Network - Toronto Western Site
West Wing, 2nd floor, 399 Bathurst Street, Toronto, ON M5T 2S8
Tel: (416) 603-5888 e-mail: michael.evans@utoronto.ca

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

Sponsoring Organizations: McMaster University
Institute for Clinical Evaluative Sciences

Starting Date: 1996 - 1997

Goals: To obtain descriptions of how family physicians detect and manage mental health problems encountered in their practices and how they function in their role as mental health providers;

To elicit their perception of barriers to delivery of optimum mental health care.

Description: Focus groups of 10-12 physicians were held in each of Ontario's seven health care planning regions. Communities were chosen to provide a mixture of rural, urban, and university settings. The size of the communities ranged from 2,000 residents to 500,000. Each focus group used standardized questions to elicit descriptive data, opinions, attitudes and terminology. Discussions were audiotaped and transcribed, analyzed using standard qualitative methods and recurring themes were summarized.

Key Findings: Family physicians agreed that caring for the mental health needs of their patients was a major part of their job, occupying 25 - 50% of their time. The problems most commonly seen were depression and anxiety, although underlying contributants such as abuse were also identified. In children and adolescents, the most commonly seen problems were behaviour problems, along with eating disorders and drug abuse. Almost all family physicians cared for patients with dementia, somatization, alcoholism, bipolar disorder, and psychotic disorders. and were frequently the only mental health care provider for these patients. Family physicians frequently commented on the difficulty posed by the undifferentiated character of problems in family practice and the frequent overlap between physical and emotional problems.

Most family physicians were comfortable with the use of antidepressants but were less likely to initiate treatment with antipsychotics. They prescribed anxiolytics with reservations. They also commented on difficulties in monitoring medications started by psychiatrists when they lacked appropriate information and backup.

Time constraints and coping with demand were major difficulties in managing psychosocial problems. Deciding whether to explore an issue tended to be based on the degree of subjective distress and the patient's ability to function. Family physicians felt the continuing relationship made it easier to judge changes in levels of distress. Crises requiring immediate attention were seen with the same degree of concern as medical emergencies. Most family physicians indicated that unexpected psychosocial problems could play havoc with their office schedule, but they simply accepted it as part of family practice. Most would schedule a return appointment to talk in greater depth about the patient's problem, often at the end of the day.

Family physicians adopted a flexible, patient-sensitive approach to care, particularly when dealing with comorbid physical and emotional problems. They saw themselves as providing counselling, but not using any particular model, and avoided jargon.

Barriers to optimum care were identified, including lack of access to psychiatric consultation and backup, psychiatrists' lack of confidence in family physicians' assessment skills, psychiatrists who refused to have hospital privileges, leaving all acute care of hospitalized patients to the family doctors, and billing tariffs which did not support counselling.

Lessons Learned: This study confirmed the importance of the family physician in the management of mental health problems. It identified a number of diagnostic and management

challenges specific to primary care and offered insights into how family physicians deal with these challenges and how they deliver mental health care. It also identified significant deficits in the relationship between family medicine and psychiatry which are perceived by family physicians to have a negative effect on their ability to deliver optimal mental health care.

Implication: There is a need for family physicians and mental health care providers to establish closer personal contacts, improve communication and look at ways to make mental health care and psychiatric consultation more accessible.

Contact: Dr. Marilyn Craven, Community Psychiatry Services, St. Joseph's Healthcare, Charlton Site, Fontbonne Building, 3rd floor, Hamilton, ON L8N 4A6
Tel: (905) 522-1155 ext. 4069 Fax: (905) 521-6059
e-mail: cravenm@mcmaster.ca

Reference: Craven MA, Cohen M, Campbell D, Williams J, Kates N. Mental Health Practices of Ontario Family Physicians: A Study Using Qualitative Methodology. Canadian Journal of Psychiatry 1997 Nov; 42(9):943-9.

CPARN Survey of Psychiatrists' Perceptions of Sharing Care with Family Physicians

Sponsoring Organizations: Canadian Psychiatric Association Research Network
CPA/CFPC Conjoint Working Group on Shared Mental Health Care

Goal: To identify psychiatrists' perceptions of the benefits of shared care and of obstacles that might make shared care more difficult.

Description: A questionnaire was sent to all 467 members of the Canadian Psychiatric Association Research Network asking corespondents about the importance of shared mental health care between psychiatrists and family physicians, collaborative activities in which they participated or in which they envisaged themselves participating, and obstacles they saw to further collaboration.

Key Findings: 246 psychiatrists (53%) responded. Questions were asked on a five-point Likert Scale. Key findings included:

- Average rating of the importance of collaboration was 4.5 out of 5.
- 20.3% of respondents spent less than five minutes with family physicians a month and 14.8% spent one hour or more. The major activity was telephone advice. It was unusual for a psychiatrist to visit family physicians' offices.
- Psychiatrists rated increased telephone contact (3.9 out of 5) and collaborative education activities (3.2 out of 5) as the most feasible ways of improving contact with family physicians.
- Major obstacles to greater collaboration were time constraints for both psychiatrists (4.2) and family physicians (4.2), lack of funding (4.1), lack of support from local health systems (3.6), and lack of reimbursement (most significant in British Columbia (4.7) and least significant in Quebec (3.1)).
- Psychiatrists felt they always contacted the family physicians by telephone after a consultation, but were less likely to do so after changing medications or discharging a patient.
- There was agreement that a treatment plan was the most important part of the consultation note, followed by a statement of the psychiatrist's ongoing role.

Lessons Learned: Findings from the survey led to several recommendations for better collaboration:

- Opportunities for joint educational/clinical rounds;
- Regular telephone contact, especially (1) after the psychiatrist changes treatment, (2) prior to discharge, and (3) following a consultation;
- Consultation notes to family physicians need to be brief and relevant to the treatment plan and should emphasize the role of the psychiatrist;
- Psychiatry residents need to be exposed to models of shared care in their training;
- Health authorities and planners need to consider collaborative models for delivering care.

Contact: Dr. Nick Kates, 40 Forest Avenue, 2nd floor, Hamilton, ON L8N 1X1
Tel: (905) 521-6133 Fax: (905) 521-6107 e-mail: nkates@mcmaster.ca

A Randomized Trial of the Effectiveness, Benefits and Comparative Costs of Sertraline vs. Interpersonal Psychotherapy, Alone or in Combination, for People with Dysthymia in Primary Care

Sponsoring Organizations: Medical Research Council of Canada, in partnership with the Pharmaceutical Manufacturers Association of Canada
Pfizer Canada Inc.

Starting Date: 1994-99

Rationale: There is little information on the long-term effects and costs of a combination of sertraline and Interpersonal Psychotherapy (IPT) for the treatment of dysthymia in primary care.

Goal: To assess the long-term (two year) comparative costs, effects and benefits associated with IPT vs. sertraline, alone or combined for people with dysthymia in primary care.

Description: Over a two-year period, 700 patients were enrolled in the study and allocated to receive IPT only, sertraline only, or a combination of the two. The study was based in a large family practice clinic and all patients were initially assessed by one of six physicians working in the practice after screening with the CIDI and the SCID. Patients could be referred to the study by other family physicians or psychiatrists. Trained therapists provided ten sessions of IPT. Management and dosage of the medication was left up to the treating physician, with treatment lasting (if tolerated) for at least 18 months. Outcomes were measured using a depression screening instrument (the MADRS), an indicator of health and social service utilisation and a quality of life scale.

Key Findings: Sertraline or sertraline plus IPT was more effective than IPT alone after six months. Over the long term (two years), all three treatments provide reasonably effective treatment for reducing symptoms of dysthymia, but sertraline or combining sertraline with IPT is more effective than IPT alone. Of these two more effective treatments, subjects in the sertraline plus IPT group had lower health and social service costs of $480 per person over two years. These findings underscore the effects of combining pharmacotherapy and psychotherapy and the economic value of this more comprehensive treatment of dysthymia in primary care.

Lessons Learned: The project studied effectiveness, versus efficacy. It is difficult to keep people on an ineffective treatment for two years. Thus, in the real world, a “pure” arm of treatment is unlikely over time.

Implication: More real world, longer-term studies are needed in primary care.

Contact: Dr. Gina Browne, Founder and Director, System-Linked Research Unit on Health and Social Service Utilization, McMaster University, Faculty of Health Sciences,
1200 Main Street West, HSC-3N46, Hamilton, ON L8N 3Z5
Tel: (905) 525-9140, ext. 22293 Fax: (905) 528-5099
e-mail: browneg@mcmaster.ca

Diagnosis and Treatment of Female-Specific Mood Disorders: A New Program for Primary Care Physicians

Sponsoring Organization: Ontario Women's Health Council

Rationale: Despite the high prevalence and significant burden of illness for individuals with depressive disorder, depression is an infrequent patient complaint and is often unrecognized by the individuals themselves, as well as by nonpsychiatric health care workers. In addition, the lifetime prevalence of mood disorders is substantially higher for adult women than it is among men. This prevalence of depression among women is primarily seen from puberty on and is less marked in the years after menopause. It is estimated, however, that primary care providers fail to diagnose and/or treat 50 to 75% of patients with depressive disorders.

Goal: To compare and evaluate evidence-based interventions which promote early recognition and treatment of female-specific mood disorders in primary care settings.

Description: Twenty primary care physicians in the community who agree to participate will be randomized to one of two interventions: Group 1 will receive written diagnosis and treatment guidelines for female-specific mood disorders, as well as background literature. Group 2 will receive the same information as Group 1, and will also participate in an intensive small-group training session.

Pre- and post-intervention data will be analyzed using patient charts and follow-up questionnaires in approximately 200 women per physician (N=4000). Data analysis will determine the incidence of missed cases of female-specific mood disorders pre- and post-intervention, as well as the differences between the two groups of physicians.

Contact: Dr. Meir Steiner, Women's Health Concerns Clinic
St. Joseph's Hospital
301 James Street South, Room F639
Hamilton, ON L8P 3B6
Tel: (905) 522-1155, ext. 3605 Fax: (905) 521-6098 e-mail: mst@mcmaster.ca

References: Zung WW, Broadhead WE, Roth ME. Prevalence of Depressive Symptoms in Primary Care. Journal of Family Practice 1993; 37:337-344.

Weissman MM, Olfson M. Depression in Women: Implications for Health Care Research. Science 1995; 269:799-801.

Mixed Anxiety-Depression in a Primary Care Clinic

Sponsoring Organizations: St. Boniface General Hospital Research Foundation
Medical Research Council of Canada
SmithKline Beecham Pharma Inc.

Starting Date: 1994

Goal: To determine the prevalence and significance of a mixed anxiety-depression (MAD) syndrome in primary care.

Description: Over an 8-week period, 924 primary care patients received a self-report handout inquiring about previous psychiatric diagnosis or treatment. 796 subjects responded negatively and 788 gave informed consent to complete the Beck Depression Inventory and the Beck Anxiety Index.

78 subjects who had BDIs of >14 or BAIs of >17 were interviewed using a version of the structured clinical interview for DSM-III-R designated SCID-FM.

Key Findings: Of the 78 patients interviewed, the mean age was 41.8 + 14.1 years. 79% were female. 10 subjects (12.8%) met the operational criteria for mixed anxiety-depression (MAD) syndrome. MAD was as common in this study as anxiety and depressive disorders among the primary care patients.

Lessons Learned: The findings of this study reveal that MAD is associated with disability comparable to that experienced by patients with full syndromal anxiety or depressive disorders. To the best of the authors' knowledge, these data are the first to reach these conclusions using operational criteria for MAD syndrome based on ICD-10, and approximate the criteria found in the DSM-IV appendix.

Implications: The preliminary data suggest that mixed anxiety-depression syndrome may best be conceptualized as a subsyndromal variant of depression. Longitudinal studies are necessary to determine the temporal evolution of MAD symptoms, to determine how to treat it and to examine whether or not treatment diminishes disability.

Contact: Dr. Peter Kirk, Department of Family Medicine
University of Manitoba, St. Boniface General Hospital
Room E6003 - 409 Tache Avenue, Winnipeg, MB R2H 2A6
Tel: (204) 235-3655 Fax: (204) 231-0302 e-mail: pkirk@cc.umanitoba.ca

Reference: Stein M, Kirk P, Prabhu V, Grott M, Terepa M. Mixed anxiety-depression in a primary-care clinic. Journal of Affective Disorders 1995; 34:79-84.

Development of a Scholarship Program in Child Psychiatry with Rural Family Physicians: A Survey Sponsored by OMA/CME Governance Committee Grant

Funding: OMA/CME Governance Committee Grant

Starting Date: February 26, 1998

Description: A working group of family physicians and child psychiatrists was formed to look into the possibility of developing a scholarship program for family physicians. Out of this working group, it was decided to hold a focus group with family physicians and one educator. The group then decided to devise a survey to distribute to rural and underserviced family physicians in Southwestern Ontario. Data collection and tabulation of results have been completed; it is expected that the findings will be ready to be presented in November 2001.

Key Findings: Based on the study's findings, the group has decided to develop some continuing medical education for family physicians, geared to their needs.

Contact: Dr. Margaret Steele, Children's Hospital of Western Ontario
Child and Adolescent Centre
London Health Sciences Centre, Health Services Building
346 South Street, London, ON N6A 4G5
Tel: (519) 667-6671 Fax: (519) 667-6814 e-mail: margaret.steele@lhsc.on.ca

Family Physicians' Perspectives on Undergraduate Psychiatry Training

Sponsoring Organization: Department of Psychiatry, University of Western Ontario

Goals: To examine family physicians' perspectives of psychiatric undergraduate education and to improve an undergraduate psychiatric curriculum;

To examine family physicians' perceptions of difficulties in access to psychiatric services and in treating psychiatric disorders;

To provide relevant and beneficial information in the planning of content and delivery of a new patient-centred, case-based, integrated curriculum redesigned from the previous traditional didactic-based approach.

Description: 258 family practice physicians in London, Ontario (population 330,000 with an estimated 324 practising family physicians) were surveyed by mail and asked to rate and rank, in order of importance to their practices, topics and skills taught in an undergraduate curriculum.

Key Findings: Topics for education (anxiety disorders, affective disorders and crisis/emergency psychiatry) and skills (assessment/diagnostic and psychopharmacological) that were most important for clinical practice were identified. Small group teaching was regarded as a preferred mode of learning.

88% of physicians identified difficulties in dealing with psychiatric problems in their practice. 69% of respondents believed that psychiatric services in their community were inadequate, and 70% identified difficulties in gaining access to psychiatric services. Physicians who reported problems in gaining access to psychiatric services had greater difficulty dealing with psychiatric problems.

Lessons Learned: This study supports the contention that primary care physicians are the major providers of psychiatric care. Many experience significant difficulties in providing care for their patients with psychiatric disorders. Improving undergraduate psychiatric curricula by emphasizing topics, skills and learning modalities considered relevant and important to primary care physicians, may improve the quality of care to patients with psychiatric disorders, the perception of difficulties in treating psychiatric problems and the need for access to psychiatric services.

Implications: The study has raised possible implications for curriculum planning in psychiatric education, including the participation of primary care physicians in curriculum planning, the selection of and emphasis on topics which reflect prevalence rates in primary care settings, and the inclusion of challenging issues such as abuse, incest and eating disorders to facilitate assessment and intervention in the primary care setting.

Contact: Dr. L. Cortese , Department of Psychiatry, London Health Sciences Centre
Victoria Campus, 392 South Street, London, ON N6A 4G5
Tel: (519) 667-6730, Fax: (519) 667-6588 e-mail:len.cortese@lhsc.on.ca

Evaluation of the Integration of Mental Health Services in Primary Care Settings

Sponsoring Organization: Hamilton HSO Mental Health & Nutrition Program

Starting Date: 1994

Rationale: The program developed to evaluate the impact of bringing mental health counsellors and psychiatrists into primary care settings.

Goals: To describe accurately services being delivered;

To determine which program components are effective and which are not;

To measure the level of satisfaction of users of the services offered.

Description: The program's evaluation consists of a large database including clinical outcomes, supplemented by other surveys and qualitative data gathered from participants in the program. The evaluation covers patients of 87 family physicians in 51 sites located across the region. Evaluation takes up approximately 6% of the program's total budget.

Data are gathered on all referrals made by the family physician, on all cases assessed by the counsellor or psychiatrist, on follow-up visits by the psychiatrist and on completion of treatment by the counsellors. The same problem list is used on each form, allowing comparisons to be made in the way problems are identified by family physicians/ counsellors and psychiatrists. Each individual has a mental health referral number which allows all services related to an episode of care to be tracked. A unique identifier preserves confidentiality and allows a longitudinal record of care to be developed. Additional data are gathered on monthly activities of the counsellors and psychiatrists. Clinical outcomes are measured with the SF-36, the GHQ, and the CES-D.

Patient satisfaction is measured with the visit satisfaction and consumer satisfaction questionnaires. Provider satisfaction is measured with a biennial questionnaire for all family physicians, counsellors and psychiatrists. Further data are gathered through visits to each practice and regular meetings with groups involved with the practice to elicit their comments on how the program is working and on changes required.

Lessons Learned: There are many logistical issues to overcome when conducting an evaluation of a program based in 51 different offices. Data gathered should be kept to a minimum and need to be useful in program development. All participants need to be asked to suggest changes in the data collected or layout of the forms, which are revised annually. Data from the evaluation need to be fed back to participants and incorporated into the program design.

Difficulties Encountered: Other than the logistic issues, many family physicians were a little reluctant to participate in an ongoing evaluation. For the first two years, each form (family physician, counsellor and psychiatrist) had to be carefully checked for errors, and often returned to the practice for completion, although this improved dramatically by the third year. Outcome measures can be difficult to complete for patients who do not complete an episode of care.

Contact: Dr. Nick Kates 40 Forest Avenue, 2nd floor, Hamilton, ON L8N 1X1
Tel: (905) 521-6133 Fax: (905) 521-6107 e-mail: nkates@mcmaster.ca

Evaluation of Geriatric Psychiatry Outpatient Consultation for Elderly Depressed Patients: Perspectives of the Patient and Family, Referring Physician and Consultant

Sponsoring Organization: Health Transition Fund, Health Canada (one-time funding)

Starting Date: June 1999

Rationale: There is a need to improve the collaborative process, particularly communication between referring and consulting physicians.

Goals: To evaluate the Outpatient Geriatric Psychiatry consultation service at St. Mary's Hospital Center. Specific objectives are:

To describe the sociodemographic profile of the patients referred for consultation;

To describe the reasons for the referral, the expectations from the consultation and the degree of pressure by the patient/family to initiate the consultation. These perceptions will be assessed independently and compared between the patient/family, the referring physician and the psychiatric consultant;

To assess the referring physician's perception of the consultation one month post-consultation, and the degree to which the recommendations of the consultant were implemented;

To assess the level of satisfaction by the patient/family immediately after the consultation.

Description: Enrolment was completed on December 31, 2000. 207 patients were screened and 149 eligible patients were enrolled.

Preliminary data has been collected on 48 patients. This includes perception of type of consultation required and the predominant reason for consult, both on the psychiatric consult form and one-month follow-up with the referring physician, and the psychiatric diagnosis on the psychiatric consultation form. Physicians rated themselves on the quality of information provided for the consultation. The reception and usefulness of the evaluation report were also rated.

Key Findings: The most common psychiatric diagnoses were depression (46%), dementia (22.9%), anxiety (2.1%) and delirium (4.2%). The psychiatrist perceived the predominant reason for consultation as follows: second opinion for diagnosis (31.3%), second opinion for management (50.0%), patient request (4.2%) and other (14.5%). At the one-month follow-up with the referring physician, the physician perceived the predominant reason for consultation as follows: second opinion for diagnosis (35.5%), second opinion for management (41.9%), other (22.6%). Physicians rated the quality of information they provided for the consultation as follows: very good (31.2%), good (53.2%), fair (15.6%). 74.0% rated the report as very useful, 14.3% rated it as somewhat useful and 10.7% rated it as not useful.

Lessons Learned: Patients need to have a clearer understanding of why they are referred to psychiatry, where they are referred, and how that referral will help their doctor better manage their case.

Increased availability of consultant and referring physicians to one another, through telephone or other means, is helpful to the treating physician in the community.

Difficulties Encountered: At times, it was difficult to schedule the one month follow-up telephone interview with referring physicians. Protocol was altered to allow mail-in questionnaires, however 60 questionnaires were not returned.

Implications: Once the limitations of the current process of referral to an evaluation service in geriatric psychiatry and potential areas for improvement are identified, an intervention protocol can be implemented which will enhance the working partnership between family physicians and psychiatrists.

Contact: Dr. Francois Primeau, Department of Psychiatry
St. Mary's Hospital Centre
3830, avenue Lacombe, Montreal, QC H3T 1M5
Tel: (514) 345-3511 ext. 3697 e-mail: francois.primeau@smhc.qc.ca

References:

Cole M, Primeau F, McCusker J. The effectiveness of intervention to prevent delirium in hospitalized patients. Canadian Medical Association Journal 1996; 155(9):1263-1268.

McCusker J, Cole M, Bellavance F, Primeau F. The reliability and validity of a new measure of severity of delirium. International Psychogeriatrics 1998; 10(4):421-433.