Caring for seriously mentally ill patients

Qualitative study of family physicians' experiences

Judith Belle Brown, PHD   Barbara Lent, MD, CCFP, FCFP   April Stirling, RSW
Jatinder Takhar, MD, FRCP   Joan Bishop, MD, FRCP

ABSTRACT

OBJECTIVE To examine family physicians' experiences in caring for patients with serious mental illness and their expectations of a shared mental health care (SMHC) model.

DESIGN Qualitative method of in-depth interviews.

SETTING London, Ont.

PARTICIPANTS Purposive sample of 11 full-time family physicians providing ongoing care for patients with serious mental illness.

METHOD Eleven interviews were conducted to explore family physicians' experiences. All interviews were audiotaped and transcribed verbatim. Analysis was done using a constant comparative approach and was carried out concurrently rather than sequentially. Researchers read all interview transcripts independently before comparing and combining their analyses. Final analysis involved examining all interviews together to discover relationships between and among emerging themes.

MAIN FINDINGS Findings reflected three main themes: what family physicians perceive they bring to care of seriously mentally ill patients (ie, whole-person approach to care); challenges family physicians face in participating in shared care of these patients (ie, communication and access issues); and family physicians' expectations of a SMHC model (ie, guidance and feedback).

CONCLUSION As seriously mentally ill patients are moved out of institutions, the need for an effective and efficient SMHC model becomes imperative. Our findings suggest that family physicians could be an important part of SMHC models but only if systemic barriers are removed and collaborative practice is encouraged.

RÉSUMÉ

OBJECTIF Examiner les expériences des médecins de famille dans les soins à des patients qui souffrent de maladies mentales graves et leurs attentes à l'endroit d'un modèle de soins en santé mentale partagés (SSMP).

CONCEPTION La méthode qualitative des entrevues en profondeur.

CONTEXTE London, en Ontario.

PARTICIPANTS Un échantillon choisi à dessein de 11 médecins de famille à plein temps qui dispensent des soins continus à des patients souffrant de maladies mentales graves.

MÉTHODOLOGIE Onze entrevues ont été effectuées pour explorer les expériences des médecins de famille. Toutes les entrevues ont été enregistrées sur bande sonore et transcrites mot à mot. L'analyse a été effectuée à l'aide d'une approche comparative constante et a été réalisée concurremment plutôt qu'en séquence. Les chercheurs ont lu individuellement les transcriptions des entrevues avant de comparer et de combiner leurs analyses. L'analyse finale comportait l'examen conjoint de toutes les entrevues pour cerner les relations entre et parmi les thèmes qui se dégageaient.

PRINCIPAUX RÉSULTATS Les constatations cernaient trois thèmes principaux: ce que les médecins de famille perçoivent comme étant ce qu'ils apportent dans les soins aux patients souffrant de maladies mentales graves (c.-à-d. l'approche à l'endroit de la personne intégrale dans les soins); les défis auxquels les médecins de famille sont confrontés dans la participation aux soins partagés de ces patients (c.-à-d. les problèmes de communication et d'accès); et les attentes des médecins de famille à l'endroit du modèle de SSMP (c.-à-d. les conseils et la rétroaction).

CONCLUSION Etant donné que les patients souffrant de maladies mentales graves reçoivent de plus en plus leur congé des établissements, il devient impératif d'avoir un modèle efficace et efficient de SSMP. Nos constatations font valoir que les médecins de famille pourraient exercer un rôle important dans les modèles de SSMP mais seulement si les obstacles systémiques sont éliminés et si la pratique en collaboration est favorisée.

Across Canada, health care restructuring is under way, and primary care reform is being actively promoted. This results in many changes to delivery of health care, particularly mental health care. The number of beds in psychiatric hospitals continues to be sharply reduced, and community-based mental health care is a reality.

Family physicians (FPs) are used to addressing the psychological and physical health concerns of patients, regardless of whether their central diagnoses reflect psychiatric illness or physical disease. The theoretical underpinnings of family medicine enable FPs to take into account the effect of health problems on patients and their families and to act as liaisons between community agencies, medical or surgical specialists, and patients and their families.

In the last decade, joint working groups of psychiatrists and FPs in both Canada and Britain have recognized the valuable contribution of both disciplines to care of patients with mental illness and have strongly recommended a shared mental health care model.[1,2] Unfortunately, government planning documents on mental health reform have often ignored the historic role FPs have had in providing care to community-dwelling patients with mental illness.[3]

Studies of FPs' contribution to mental health care have focused mostly on patients with anxiety and depression[4,5] or on patient outcomes.[6] One of the few studies looking at FPs' involvement with patients with serious mental illness found that FPs cared for only a few long-term mentally ill patients in their practices, but saw these patients more frequently than other patients and managed both their physical disorders and psychotropic medications.[7]

This study looks at the issue from a different perspective, by examining FPs' experiences in caring for seriously mentally ill patients. Such patients

··

Dr Brown *is a Professor with the Centre for Studies in Family Medicine and the Thames Valley Family Practice Research Unit at the University of Western Ontario (UWO) in London.* **Dr Lent** *is an Associate Professor in the Department of Family Medicine at UWO and a staff physician at the Victoria Family Medical Centre.* **Ms Stirling** *is a social worker at Regional Mental Health Care in London.* **Dr Takhar** *is an Assistant Professor in the Department of Psychiatry at UWO and a Consultant Psychiatrist at the London Health Sciences Centre.* **Dr Bishop** *is an Associate Professor of Psychiatry and Family Medicine at UWO and Staff Psychiatrist at Regional Mental Health Care.*

are defined for the purposes of this study as having a primary diagnosis of schizophrenia or bipolar disorder. The study also explores FPs' experiences and expectations of a shared mental health care (SMHC) model. We hope this information will be helpful as further changes in the mental health care system are planned.

METHODS

In-depth interviews were used to gain an understanding of FPs' experiences. This qualitative method has been used previously to explore FPs' participation in providing other specialized services, such as palliative and obstetric care.[8-10]

Consistent with qualitative methods, participants were purposefully selected to ensure a maximum variation sample and a variety of perspectives.[11,12] Potential participants were identified by the researchers; all 11 FPs contacted by telephone agreed to participate. Participants were six women and five men who had been in practice from 1 to 30 years. Seven were in group practice and four were in solo practice. All physicians except one were reimbursed on a fee-for-service basis. Eight were Certificants of the College of Family Physicians of Canada. All cared for patients with mental health problems and had shared such care with other health care professionals.

A semistructured interview consisting of open-ended questions was developed to explore FPs' role in caring for seriously mentally ill patients, their practice behaviour, past and current experiences with SMHC, and expectations of a SMHC model. The schedule of questions was flexible, serving as a framework for interviews. All interviews were conducted by the first four authors (J.B.B., B.L., A.S., and J.T.). None of the interviewers was affiliated with participants' practices. All interviews were audiotaped and transcribed verbatim.

The analysis strategy used a constant comparative approach with the first three investigators independently reading the transcripts and initially looking for key words and emerging themes. They then met to compare and combine their independent analyses, which served to expand and test the emerging concepts and themes identified in the interviews.

Data collection continued until researchers agreed they had reached theme saturation; this had occurred by the 11th interview.[12] The final stage of analysis involved examining all interviews with the NUD*IST program, a qualitative analysis software package.[13] This program helped identify relationships between

and among central themes, condense the data, and identify relevant quotes to illustrate findings.

We used member checking to enhance the credibility of the findings.[12] When analysis was completed, a summary of findings was distributed to participants for their comments and feedback. Researchers attended to personal and professional biases that could influence their interpretation of the data through extensive discussion and personal reflection.[12]

This study received ethics approval from the Review Board for Health Sciences Research Involving Human Subjects at the University of Western Ontario in London.

FINDINGS

Findings reflected three main themes: what FPs perceive they bring to care of seriously mentally ill patients; the challenges FPs face in participating in shared care of these patients; and FPs' expectations of a SMHC model.

What FPs bring to care
All participants believed that, as FPs, they had a commitment to caring for patients with a variety of clinical problems including serious mental illness.

> You kind of take what comes through the door and whenever it comes to us you try to help to deal with it. … I believe that's a piece of what I bought into when I became a family doctor.

In enacting this "family medicine philosophy," as one participant described it, the concept of continuity was central. This included offering "support" and "consistency" and being available on an ongoing basis. "[I was] somebody who hung in with her over the long haul."

Participants noted that some mentally ill patients found it more acceptable to come to FPs' offices than see a psychiatrist or attend a psychiatric hospital. "The family doctor is seen as, or should be seen as, somebody who is less threatening, more comfortable, more approachable." Even if physicians were not actively involved in patients' treatment, continuity of care remained: "I don't abandon these people. Just because I refer them doesn't mean that they're gone."

Another feature of the "family medicine philosophy" was caring for all aspects of patients—emotional, social, and physical. "You always have to be doing both. You do a full investigation from an organic point of view. You have to do that in addition to handling the psychiatric problem." This holistic approach to care included an understanding of the many challenges facing mentally ill patients. "They're going to have to deal with voices, financial troubles, Children's Aid breathing down their back, landlords after them for money." As one participant observed, however, the enormity of the problems presented by patients could place more attention on that aspect of their lives to the detriment of whole-person care.

> I worry sometimes that I am paying so much attention to their mental health issue that I don't have an opportunity or I forget to think about giving good medical care. … It's then hard to remember when did I last take a blood pressure or do a Pap smear. …

While committed to the care of seriously mentally ill patients, participants commented on how both exposure to and experience with these patients helped them feel comfortable in providing their care. Most participants described having only small numbers of seriously mentally ill patients in their practices.

Challenges of shared care
Participants described a variety of experiences, both positive and negative, in participating in shared care of seriously mentally ill patients. Positive experiences were characterized by a collaborative approach that included good communication, access to and availability of psychiatric care, backup, and timely feedback. As one participant described:

> They [psychiatrists] see people quickly and produce a nice note and generally give you very clear direction. A few of the community psychiatrists have also been good about providing telephone support so that you can phone them up and say "I've got this issue, I think I can manage it. This is what I think I should do. From what I've told you yes or no?" They will often say "Yes, I think you're on the right track."

When there was no collaborative relationship, shared care faltered, and participants described problems such as poor communication, lack of access, fragmentation, and lack of accountability. Problems in communication included transfer of information about patients' admissions and discharges as well as ongoing care.

> When the patient has been in hospital and discharged, it would be nice to have some kind of contact with the

psychiatrist who treated them. To let you know a) that the patient has been in, b) [the patient] is going out, and c) this is the plan.

At times, accessing psychiatric care for patients was difficult:

They might not be desperate or urgent enough to be sent to the emergency department. … [So] you spend half to three-quarters of an hour phoning and being told, "that's not our responsibility!" You finally say: "Well that's it, go to the emergency department." That's not good for patients. It's not good for the emergency department.

Participants acknowledged that part of the accessibility issue was related to how few psychiatrists were available to provide care:

That's not the fault of the psychiatrist;… it's a lack of numbers. I mean, they're all just too busy. They do a good job, whenever you can get a patient in to see them.

Challenges in shared care were also attributed to fragmentation of care. The following story illustrates participants' frustrations with fragmentation and suggests that communication is at the root of the problem.

I had a patient present to my office 2 days ago who had been in a psychiatric facility for 6 months last year. I received no notes. I had received a discharge note from a consulting psychiatrist at another psychiatric facility 2 months ago when she was discharged to the outpatient care program and have had no further communication. She presented to my office because she thought she was toxic on her Tegretol (carbamazepine). She had talked with the consultant's resident at the second facility that day who told her to come to my office and get some bloodwork done. … So it makes it very difficult to kind of jump in when you have no idea what the hell's going on. It makes it exceedingly difficult in that particular type of case to have no communication from the consultant.

Related to the issue of fragmentation was participants' frustration with the decline in services for seriously mentally ill patients.

A lot of these folks with serious mental illness aren't particularly appropriate for psychotherapy… but need more support than they have in the community. … I find those services have dried up.

From their own practice perspective, participants described the extra time required to care for these patients, particularly when they were in crisis. "They do take a lot more time, and I don't always get paid for all the time and effort." Beyond issues of remuneration and time expended, participants also commented on the need to find a balance between their responsibilities to seriously mentally ill patients and other clinical responsibilities.

Family physicians' expectations of a SMHC model

Participants endorsed working within the framework of a SMHC model: "I visualize shared care as working side-by-side. It's the way I personally feel that doctors work best and that's working in close communication with others." They envisioned a SMHC model as enabling them to share patient care responsibilities with other professionals:

Having a psychiatrist that one could access or a mental health care expert… not only for drug advice but to run patient scenarios by… to come in quickly and see a patient once or twice, maybe even in your own office. … Then to create an opinion, help give some direction and again a willingness to have ongoing input into the patient's psychiatric care.

Participating in a SMHC model also provided reassurance and feedback. As one participant noted, "Either to reassure me that what I'm doing is the best thing or to give advice as to what to do."

Central to a SMHC model was FPs' expectations of a "timely" response to requests for assistance. "I need a psychiatrist who says 'When you have an urgent problem, you can call me and I'll get back to you in a couple of hours.'" A rapid response was most critical when a patient was in crisis. "If somebody is out of control in your waiting room, you don't want to wait 5 hours for a phone call." A SMHC model would also assist FPs with administration of complex psychotropics.

I need the backup because I don't have the expertise to manage five drugs in cocktails that psychiatrists put together… but I am prepared to work with people, particularly if you can have a curb-side consult or over-the-phone consult.

As for their role in a SMHC model, participants viewed their contribution as providing "support" and "ongoing care," and being "a liaison person … who reinforces what the psychiatrist is doing."

I'm thinking of one paranoid schizophrenic, who every so often will decide to stop all her medication. A really important role for me is to reinforce the importance of taking her medications. So I often say "Can I call your psychiatrist, can I call the psychiatric nurse and just tell them you're having difficulty taking your meds?"

When patients were admitted to hospital, participants saw their role as trying "to do the best I can to pick up the pieces in the family while the hospital stabilizes the patient."

Finally, some participants believed that having the structure and support of a SMHC model would allow them to care for more seriously mentally ill patients.

If that support from a shared care model was always available then yes, I would take on more of these patients because for me it would not only be a good clinical experience it would be a learning experience.

Others were hesitant to assume additional responsibilities in caring for seriously mentally ill patients in the context of their current clinical demands. "It would be … difficult … because I don't take new patients any more because I'm too busy taking care of my own. … I don't have room for anybody else."

DISCUSSION

Participants were committed to caring for seriously mentally ill patients as they would care for patients with other chronic health problems. Noteworthy was our participants' endorsement of caring for this patient population from a family practice perspective, taking into consideration the physical, emotional, and social aspects of patients' lives. The extensive psychiatric needs of these patients, however, could take attention away from management of other health problems and from the usual health promotion services FPs provide.

Although the number of seriously mentally ill patients was relatively small, demands in terms of time and effort were often high, particularly when patients were in crisis (as found in a study of British FPs[7]). A SMHC model might make it easier for FPs to play their role in management, including crisis intervention, support, continuity, and advocacy.

Our participants described various systemic challenges to participating in a SMHC model, such as limited access to psychiatric services and poor communication. Their subsequent frustration reinforced their reluctance to increase their involvement in caring

Editor's key points
- This qualitative study reports on the experiences of 11 family physicians caring for patients with serious mental illness and the challenges they faced in participating with other professionals in a model of shared mental health care.
- Seriously mentally ill patients require a holistic approach to management; they have psychological symptoms, concomitant physical diseases, and financial and social problems. Their psychological problems are often so severe that their other problems are ignored.
- Although some experiences were positive, family physicians reported poor communication, insufficient access to psychiatrists, and a lack of continuity in mental health care.

....

Points de repère du rédacteur
- Cette étude qualitative rapporte les expériences de soins conjoints en santé mentale de 11 médecins de famille et leurs attentes face à un modèle de soins en santé mentale en collaboration avec d'autres professionnels.
- Les patients souffrant de maladies mentales graves présentent plusieurs défis cliniques nécessitant une approche globale: symptômes psychologiques, maladies physiques concomitantes, problèmes financiers et sociaux. Les problèmes psychologiques de ces patients sont souvent si importants que les soins de santé physique sont négligés.
- Bien que certaines expériences soient positives, les médecins ont rapporté que dans d'autres situations, il y avait un manque de communication, un manque d'accessibilité aux psychiatres et un manque de continuité dans les soins en santé mentale.

for seriously mentally ill patients. Such care was made even more difficult by having family practices that are already overburdened. Physicians had little discretionary clinical time. Nonetheless, participants viewed this patient population as needing their assistance and were seeking a more collaborative relationship with psychiatric professionals to facilitate this component of patient care. Similar themes have been found in other studies.[14]

Several aspects of the current health system limit FPs' involvement with such patients. A well-planned SMHC model, as described by Canadian and British joint working groups on mental health care,[1,2] could address some of the challenges described here, but

broader changes in the health care system will be required to address existing barriers.

Limitations and future studies

Participants were recruited from a single geographic area within which there was a large psychiatric facility. Participants might have come to rely on the specialized psychiatric services available at this facility. These factors limit transferability of our findings to other Canadian FPs. Future studies need to look at patients' perspectives and those of other health care professionals participating in SMHC models.

Conclusion

As seriously mentally ill patients are moved out of institutions, effective and efficient shared care becomes imperative. Our findings suggest that family physicians could be an important part of SMHC models but only if systemic barriers are removed and collaborative practice is encouraged. ✤

Contributors

Drs Brown *and* **Bishop** *conceived the project and, with* **Drs Lent** *and* **Takhar***, prepared the proposal for the research grant.* **Drs Brown, Lent,** *and* **Takhar** *and* **Ms Stirling** *participated in data collection and analysis.* **Drs Brown** *and* **Lent** *and* **Ms Stirling** *contributed to writing the manuscript. All the authors helped develop the methodology and participated in preparing the final manuscript for publication.*

References

1. Kates N, Craven M, Bishop J, Clinton T, Kraftcheck D, LeClair K, et al. *Shared mental health care in Canada*. Ottawa, Ont: Canadian Psychiatric Association and College of Family Physicians of Canada; 1997.
2. Royal College of Psychiatrists, Royal College of General Practitioners. Shared care of patients with mental health problems: report of a joint college working group. *Occas Pap R Coll Gen Pract* 1993;60(May):1-10.
3. Ontario Ministry of Health. *Putting people first: the reform of mental health services in Ontario*. Toronto, Ont: Ontario Ministry of Health; 1993.
4. Wilkinson G. The role of primary care physicians in the treatment of patients with long-term mental disorders. *Int Rev Psychiatry* 1991;3:35-42.
5. Katon W, Gonzales J. A review of randomized trials of psychiatric consultation-liaison studies in primary care. *Psychosomatics* 1994;35:268–78.
6. Wood K, Anderson J. The effect on hospital admissions of psychiatric case management involving general practitioners: preliminary results. *Aust N Z J Psychiatry* 1994;28:223-9.
7. Burns T, Kendrick T. Care of long-term mentally ill patients by British general practitioners. *Psychiatr Serv* 1997;48:1586–8.
8. Carroll JC, Brown JB, Reid A. Women family physicians in obstetrics: achieving personal well-being. *Can Med Assoc J* 1995;153:1288-9.
9. Brown JB, Carroll J, Reid A. How family influences practice of obstetrics. Do married women family physicians make different choices? *Can Fam Physician* 1996;42:1319-26.
10. Brown JB, Sangster M, Swift J. Factors influencing palliative care. Qualitative study of family physicians' practices. *Can Fam Physician* 1998;44:1028-34.
11. Patton MQ. *Qualitative evaluation and research methods*. 2nd ed. Newbury Park, Calif: Sage Publications; 1990.
12. Crabtree BF, Miller WL, editors. *Doing qualitative research*. 2nd ed. Thousand Oaks, Calif: Sage Publications; 1999.
13. Richards T, Richards L. The NUD*IST qualitative data analysis system. *Qual Sociol* 1991;14:307-24.
14. Velamoor R, Mendonca J, Grindrod A, Graham N, Hennen B. *A summary of the results of a survey to London and area family physicians about their problems in dealing with psychiatric crisis in the community* (unpublished document). London, Ont: Centre for Studies in Family Medicine and the Department of Psychiatry, University of Western Ontario; 1998.