

Management of mental health problems by general practitioners in Quebec

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Abstract

Objective To document the management of mental health problems (MHPs) by general practitioners.

Design A mixed-method study consisting of a self-administered questionnaire and qualitative interviews. An analysis was also performed of Régie de l'assurance maladie du Québec administrative data on medical procedures.

Setting Quebec.

Participants Overall, 1415 general practitioners from different practice settings were invited to complete a questionnaire; 970 general practitioners were contacted. A subgroup of 60 general practitioners were contacted to participate in interviews.

Main outcome measures The annual frequency of consultations over MHPs, either common (CMHPs) or serious (SMHPs), clinical practices, collaborative practices, factors that either support or interfere with the management of MHPs, and recommendations for improving the health care system.

Results The response rate was 41% (n=398 general practitioners) for the survey and 63% (n=60) for the interviews. Approximately 25% of visits to general practitioners are related to MHPs. Nearly all general practitioners manage CMHPs and believed themselves competent to do so; however, the reverse is true for the management of SMHPs. Nearly 20% of patients with CMHPs are referred (mainly to psychosocial professionals), whereas nearly 75% of patients with SMHPs are referred (mostly to psychiatrists and emergency departments). More than 50% of general practitioners say that they do not have any contact with resources in the mental health field. Numerous factors influence the management of MHPs: patients' profiles (the complexity of the MHP, concomitant disorders); individual characteristics of the general practitioner (informal network, training); the professional culture (working in isolation, formal clinical mechanisms); the institutional setting (multidisciplinarity, staff or consultant); organization of services (resources, formal coordination); and environment (policies).

Conclusion The key role played by general practitioners and their support of the management of MHPs were evident, especially for CMHPs. For more optimal management of primary mental health care, multicomponent strategies, such as shared care, should be used more often.

EDITOR'S KEY POINTS

- This study confirms the importance of the management of mental health problems (MHPs), especially common MHPs, by general practitioners. These patients are among the heaviest users of general practitioner care.
- The study identified a number of factors that affect the management of MHPs, including patient profiles; the professional culture (working in isolation, informal clinical mechanisms); and organization of services (lack of access to resources and formal mechanisms of coordination). Supporting factors included the following: characteristics of general practitioners, the institutional setting, and environment.
- Most primary mental health care is delivered by general practitioners. Nearly all of the general practitioners believed themselves to be competent to treat common MHPs; only a minority (17%) believed themselves to be competent to treat serious MHPs.

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According to the World Health Organization, by 2030, mental health problems (MHPs), specifically depression, will be the main cause of morbidity in the industrialized world.¹ The economic and social costs associated with MHPs are substantial.² The prevalence of MHPs over the course of 1 year ranges from 4.3% (China) to 26.4% (United States).³ In Canada, this rate is estimated to be 11% (Quebec: 10.3%). Approximately 40% of patients use health services for reasons of mental health.^{4,5} However, detection and adequacy of treatment of MHPs have been determined to be less than optimal.⁶ Substantial reforms have been introduced in recent years to improve the efficacy of mental health services. The aim of these reforms has been to consolidate primary care and practices, supported by evidence-based data and fuller integration of care. It has been established that countries with an effective primary care system generally have a population in better health.⁷ Similarly, the deployment of best practices and an integrated system of care are associated with better quality of and increased satisfaction with services.⁸

The reforms^{9,10} that are under way in Quebec reflect these global trends. They aim to improve the management of MHPs by enhancing primary care and shared care (coordination between general practitioners, psychosocial professionals, psychiatrists, etc). Most primary mental health care is delivered by general practitioners.⁵ In Quebec's action plan for mental health, *Plan d'action en santé mentale 2005-2010*,⁹ the care they deliver must be coordinated with the services of the mental health teams working out of Quebec's health and social service centres with a local community service centre mission and with responding psychiatrists (shared care), a recent addition. *Guichets d'accès*, or *care access counters*, coordinated by these health and social service centres have also been added to introduce mental health services into the local service networks (n=95, corresponding to the territories of the health and social service centres and integrated into 18 health and social service administrative regions).

In this context, the objective of this article is to identify the clinical and collaborative practices of general practitioners in Quebec. This article describes the scope of the management of MHPs by general practitioners, collaborative practices, conditions for success, and recommendations for improving primary mental health care, with the goal of supporting decision makers in the organization of mental health services.

METHODS

The study used both a quantitative method (survey) and a qualitative method (interviews). Administrative data from Régie de l'assurance maladie du Québec (RAMQ)

for all medical procedures performed in 2006 (and 2002) were also analyzed so that they could be compared with the collated survey results (proportion of mental health procedures, mental health procedures as a proportion of all medical procedures, etc).¹¹ The general practitioners we contacted were from urban, semiurban, and rural regions (9 local service networks in 5 health and social service administrative regions). A range of practice settings was taken into consideration: private practices, medical clinics, health and social service centres, hospitals (general hospitals with health and social service centres, psychiatric hospitals, etc), family medicine groups, network clinics, and walk-in clinics. Using a list provided by the Fédération des médecins omnipraticiens du Québec, 1415 general practitioners (ie, 20% of general practitioners in Quebec) were selected and sent the questionnaire between September 2006 and February 2007. The questionnaire (self-administered; 30 minutes) comprised 143 items, covering 6 areas: sociodemographic profile of the general practitioner, profile of his or her patients, clinical practices, scope of interprofessional collaboration, perceived quality of services, and strategies for collaboration that should be promoted. It was subjected to descriptive analysis, and illative analysis in SPSS, version 17.0. The methodology of this study is presented in greater detail in other publications.^{12,13}

The purpose of the interviews, which were conducted from April 2009 to March 2010 based on a subsample of the survey, was to complement the quantitative results extracted from the questionnaire. For comparison purposes, these general practitioners also completed a scaled-down version of the questionnaire (27 items, 10 minutes). Based on a list taking into account the administrative territories and practice settings described above, 124 general practitioners were approached (target: n=60; 12 general practitioners per region). Strategies for approaching the general practitioners included sending letters by mail, e-mail, and fax, and making telephone calls. The interviews (70 minutes) were conducted using a guide and comprised 3 sections: clinical practices (professional path, influence of the practice setting, development of skills, etc); partnership and reform (availability of resources, factors promoting or interfering with collaboration, evaluation of changes, etc); and needs in terms of support and ideal practice models that need to be developed in mental health. Interviews were conducted over the telephone (75%) or in person (25%) by the authors of the article. All the interviews were transcribed, coded, and analyzed using NVivo 8 in accordance with the sections in the interview guide (clinical and collaborative practices, factors promoting or interfering with collaboration, etc). The research was supported by key decision makers and approved by the Douglas Mental Health University Institute ethics committee in Montreal, Que.

RESULTS

Profile of the sample

Of the 1415 general practitioners who were approached to complete the questionnaire, we contacted 970 practising in the local service networks being studied. Overall, 398 responded to the questionnaire, providing a 41% response rate. The sample was compared with the population of general practitioners in Quebec on a number of variables (sex, age, method of remuneration, types of territory, etc); no significant differences were identified.^{12,13} Of the 124 general practitioners who were approached to reach the target of 60 interviews, 29 were excluded because they had moved, retired, or could not be reached, which resulted in a 63% response rate. These general practitioners were compared with the 398 general practitioners from the quantitative sample with regard to sex, age, and rate of fee for service (Table 1¹⁴). No significant differences were noted. However, compared with the population of general practitioners in Quebec, the rate of fee for service was lower in the subsample of 60 general practitioners. The results of the comparison of our sample to nonrespondents were not significant for sex ($\chi^2=0.50$, $df=1$, $P=.4777$) or age ($F=0.10$, $P=.921$). The overall characteristics of the samples are presented in Table 2. These are described in greater detail in other publications.^{12,13,15}

Management of MHPs and collaborative practices

According to the RAMQ data, 3 of 4 people in Quebec consulted general practitioners in 2006: 20% consulted for mental health reasons (ie, 15% of the general population older than 18 years of age). The data show that, compared with patients with no MHPs (no diagnosis or

procedure related to an MHP), these patients account for 37% of all medical procedures (Table 3). According to the survey, 25% of patients who saw general practitioners presented with MHPs, 55% of which were associated with common MHPs (CMHPs), 11% with serious MHPs (SMHPs), and 34% with concomitant disorders (MHPs and physical issues, substance abuse, or intellectual deficit). Nearly 90% of general practitioners provide ongoing care to patients presenting with CMHPs; this rate is 76% for SMHPs. However, 75% of these general practitioners care for only a few cases of SMHPs. Nearly 70% of patients presenting with SMHPs are seen on a walk-in basis. The survey and interviews also indicate that general practitioners make scant use of clinical tools (eg, self-care, clinical protocols, MHP screening tools) and formal collaboration (shared care) to support their practices. In most cases, consultations are limited to monitoring medication or providing support therapy (Table 2). According to the survey, the frequency of visits for patients presenting with CMHPs is 9 times a year; the frequency of visits for patients presenting with SMHPs is 6 times a year. Nearly all of the general practitioners believed themselves to be competent to treat CMHPs; only a minority (17%) believed themselves to be competent to treat SMHPs. Those who did believe themselves to be competent to treat SMHPs had had more specialized training in mental health and were more likely to be practising in semiurban and rural regions with limited access to psychiatric resources. Most had practised in psychiatric hospitals or were practising in health and social service centres with local community service centres.

When asked about their interprofessional relationships, more than 50% of general practitioners responded that they have no contact with resources in mental health (psychiatrists, health and social service centre

Table 1. Comparison between 2 samples of GPs (survey group and interview group) and the total population of GPs in Quebec

CHARACTERISTIC	SURVEY GROUP (N = 398)	INTERVIEW GROUP (N = 60)	P VALUE FOR χ^2	GPs IN QUEBEC,* %	P VALUE FOR χ^2
Age, [†] y, n (%)			.350		.350
• < 35	29 (7.3)	1 (1.7)		13.7	
• 35–44	112 (28.1)	9 (15.0)		27.5	
• 45–54	170 (42.7)	24 (40.0)		35.0	
• 55–64	74 (18.6)	22 (36.7)		18.3	
• ≥ 65	13 (3.3)	4 (6.7)		5.5	
Sex, n (%)			.670		.322
• Male	194 (48.7)	29 (48.3)		55.1	
• Female	204 (51.3)	31 (51.7)		44.9	
Mean (SD) percentage of fee for service	64.9 (39.8)	54.8 (37.8)	.149	74.0	.005

*Data from Savard and Rodrigue.¹⁴

[†]Mean (SD) age of GPs who took part in the survey was 48 (9) y. Mean age of GPs who took part in the interviews was 52 (8) y.

Table 2. Profiles of GPs and patients: *N* = 398 respondents.

CHARACTERISTIC	TYPE OF MHP		
	MHP	CMHP	SMHP
GP practice settings and hours worked, mean (SD)			
• No. of practice settings*	2 (1.0)		
• Hours worked per wk	43 (12.8)		
GP clinical profiles, n (%)			
• GPs who manage MHPs ^{††}	360 (90.5)	354 (88.9)	304 (76.4)
• GPs who monitor medication		243 (61.1)	195 (49.0)
• GPs who provide support therapy		236 (59.3)	139 (34.9)
Patient profiles, mean (SD)			
• Patients seen each wk for all reasons	90.0 (42.0)		
• Patients seen each wk for mental health issues	22.5 (25.0)	19.9 (88.5)	2.6 (11.5)
• Proportion of patients presenting with MHPs	25.0 (19.0)		
• Patients with MHPs whose care is managed by GPs, out of the patients seen per wk for MHPs		13.7 (69.0)	0.8 (34.0)

CMHP—common mental health problem, MHP—mental health problem, SMHP—serious mental health problem.

*For the sample of 60 GPs who were interviewed, the mean (SD) number of practice settings is 2.8 (1.2).

[†]For the sample of 60 GPs who were interviewed, the number (percent) is 60 (100) for MHPs.

^{††}GPs answered a yes or no question, and had at least 1 patient.

Table 3. Patients in Quebec older than 18 y who consulted GPs: *Régie de l'assurance maladie du Québec administrative data.*

CATEGORY	CONSULTED AT LEAST ONCE FOR REASONS OF MENTAL HEALTH	CONSULTED FOR A REASON OTHER THAN MENTAL HEALTH	TOTAL PATIENTS WHO CONSULTED GPs
No. of patients in 2006	909 850	3 630 824	4 540 674
Patients in Quebec older than 18 y in 2006, %	15.0	59.9	74.9
Change since 2002, %	+ 6.6	+ 3.1	+ 3.1
Patients who consulted GPs in 2006, %	20.0	80.0	100

professionals, psychologists in private practice, community agencies, etc). Referrals are the most commonly used strategy for meeting the extensive needs of their patients. General practitioners estimate that they refer 17% of their patients with CMHPs (31% to psychologists in private practices, 29% to local community service centres, 13% to psychiatrists, and 7% to community agencies). They refer 71% of patients with SMHPs, mainly to psychiatrists and emergency departments. They make scant use of community agencies and crisis centres. During the survey and interviews, it emerged that general practitioners believe that the mental health system is of poor quality, particularly with respect to accessibility and continuity of care (**Table 4**); however, they are strongly in favour of improving the system and of receiving greater support of their clinical activities.

Factors that influence management of MHPs and collaboration with mental health resources

The physicians we interviewed identified 7 factors that support the management of MHPs: a multidisciplinary practice, particularly in a health and social service

centre (salary-based or hourly fee-based); a high volume of patients with MHPs whose cases are not overly complex; specific training in mental health care (basic or continuing education); limited access to psychiatric services, forcing them to be involved; a marked interest in MHPs; good interpersonal skills (listening, empathy); and patient registration. Interprofessional collaboration is supported when general practitioners work primarily in health and social service centres; practise or have practised in a hospital; have a wide, informal network in the mental health field (including general practitioners specializing in mental health); and practise in networks in which shared care practices are employed, including assessment-liaison modules (referral services for general practitioners that are usually created by university hospital psychiatric departments).

The interviews revealed several factors that limit the management of MHPs: the inadequacy of mental health resources; wait times for care, specifically for psychiatry (on average, 60 days, according to the survey) and psychotherapy in health and social service centres; lack of information about wait times; a limited number of

Table 4. Interprofessional collaboration between GPs and mental health professionals according to survey: N = 398.

CATEGORY	FREQUENCY, %
GPs who referred or transferred patients owing to the following:	
• Severity of MHP	67.1
• Complexity of case	70.4
• Lack of support from psychiatrists	28.5
• Lack of expertise in mental health	11.3
• Lack of interest in mental health	4.4
• Lack of financial incentives	8.5
GPs who reported that the mental health system is adequate or very adequate, with respect to the following:	
• Health system as a whole	55.0
• Geographic accessibility	64.0
• Hours of operation	59.0
• Range of services	54.0
• Continuity of services	46.0
• Availability of services	35.0
• Accessibility of mental health professionals	27.0

MHP—mental health problem.

psychotherapy sessions; the challenges of communicating with mental health resource providers; the lack of availability of general practitioners, reflecting a shortage of resources and increased demand; the inadequacy of incentives to collaborate on or manage MHPs, including fee for service; bureaucracy and inadequate procedures for referral and coordination; the lack of stability in the network, specifically the lack of stability in human resources; training that does not support collaborative practices; and the heavy workload associated with treating patients with MHPs (eg, increased length and number of consultations, importance of concomitant issues, high level of emotional involvement by general practitioners, the work involved in following up with insurance companies). Even when access to psychiatrists is facilitated, general practitioners report that, when needed, stepped care is inadequate, as is more intensive psychiatric management when a patient's condition requires it, psychiatric services in the evenings and on weekends, and psychiatrists for semiurgent cases (urgent cases can be treated in a hospital emergency department).

Strategies and recommendations for improving management

The general practitioners we interviewed suggested the following strategies for addressing the factors interfering with adequate management of MHPs: optimizing their informal collaborative network; providing more consultations for each patient ("solve one issue per

consultation"); meeting patients at the beginning or the end of the day; creating specific times in which to manage potential crises and walk-in visits; and encouraging self-referrals to more appropriate practice settings such as health and social service centres or hospitals (if they also practise at these locations). During the interviews, most general practitioners (62%) supported the development of adequate financial incentives to manage MHPs and support collaboration. They believed that collaboration would lead to an increase in their case load of new patients.

During the interviews, the general practitioners also reported that greater access to psychotherapists and psychiatrists was needed. Nearly 75% believed that psychotherapy (particularly cognitive behavioural therapy) in combination with medication was a best practice for CMHPs that should be promoted. Nearly half (55%) were in favour of more contact with psychosocial professionals, particularly psychologists, in the form of brief reports or telephone calls identifying treatment objectives, proposed strategies, and anticipated duration of treatment. The interviews revealed that shared care under the leadership of a psychiatrist was the preferred strategy for treating more complex CMHPs and SMHPs; case complexity and severity of MHP were the main reasons for referrals to psychiatry given by the general practitioners in the survey (Table 4). In the survey, the general practitioners also recommended monthly visits to their clinics (48%) and weekly support in the form of telephone calls from psychiatrists (95%), as well as training every 3 months (72%) in the form of multidisciplinary case studies under the leadership of psychiatrists from the local service network.

During the interviews, 88% of general practitioners were in favour of adding nurses with expertise in mental health in order to help them prioritize the patients, collect relevant information (eg, social support, lifestyle), deliver psychoeducational services (with the family), reinforce compliance with medications, and manage more complex cases of MHPs. They were also in favour of collaboration with social workers (rehabilitation, health and social service centres) and community agencies for patients with SMHPs, and collaboration with addiction treatment centres for patients with concomitant disorders. Respondents reported that responsibility for coordination with these agencies should fall to the local community service centres or health and social service centres.

DISCUSSION

In light of the reforms that are currently under way, the purpose of this study was to examine the scope of general practitioner management of MHPs, clinical and

collaborative practices, the factors that support or interfere with primary mental health care, and recommendations for improving primary mental health care. This study confirms the importance of MHP management, specifically CMHP management, by general practitioners as reported in the literature.^{16,17} According to our study and recent research, mental health patients are among the heaviest users of general practitioner services.^{16,18} The general practitioners in our study believe that they have the skills to adequately treat CMHPs, and this is in line with recent research.^{19,20} However, in Quebec and elsewhere,^{21,22} they believe that they are ill equipped to adequately treat SMHPs and they treat them less often. Given the scope of the health care needs and stigmatization of patients presenting with SMHPs,²³ access to general practitioners for these vulnerable patients represents a considerable challenge.

The study identified a number of factors that affect the management of MHPs. Inhibiting factors include the following: patient profiles (complexity of MHPs, concomitant disorders, intensity of management); the professional culture (working in isolation, informal clinical mechanisms); and organization of services (lack of access to resources and formal mechanisms of coordination). Supporting factors include the following: characteristics of general practitioners (informal networks, training in mental health, empathy); the institutional setting (health and social service centres, multidisciplinary, salaried status); and the environment (national policies and international trends in the delivery of primary care).

This study also identified the less-than-optimal conditions under which general practitioners manage MHPs, such as inadequate interdisciplinary relationships and psychosocial and psychiatric resources; and follow-up that exceeds the guidelines (eg, 10 consultations per year, particularly for depression²⁴). Increasingly, the research points to the importance of increasing access to treatment based on the biopsychosocial model and stepped care, depending on the severity of the illness, to improve the efficiency of services from patient self-management of care or psychotherapy to the supervision of compliance with medication or even intensive care, including shared mental health care.^{25,26} These interventions require an interdisciplinary approach in which the general practitioner is at the centre of care delivery, but is strongly supported by psychosocial professionals and psychiatrists.^{27,28} Such an overhaul of the primary mental health care system would evolve from an examination of the practices of general practitioners to an examination and further strengthening of the overall organization of care delivery.


In spite of the fact that recent reforms in Quebec^{9,10} acknowledge the central role played by general practitioners in the management of MHPs, their integration

into the overall delivery of care, as well as changes in their practices, have gone largely unnoticed. The partial implementation of mental health care teams in the health and social service centres and shared care teams²⁹ explain, in part, why general practitioners work mostly in isolation.

Limitations

General practitioners who were interested in treating patients with MHPs were more likely to respond to the survey, particularly the qualitative component. The qualitative sample contains a lower proportion of general practitioners paid on a fee-for-service basis than in the general medical population in Quebec. Finally, the survey was conducted in the early stages of the implementation of Quebec's mental health action plan, *Plan d'action en santé mentale 2005-2010*,⁹ and the interviews were conducted toward the end of the reform. However, our results do not reflect any changes in the perceptions of general practitioners with respect to management of, or collaboration over, mental health cases.

Conclusion

This study demonstrates the key role played by general practitioners and their support for the consolidation of front-line management of MHPs, specifically CMHPs. Owing to large organizational barriers, general practitioners tend to work in isolation under conditions that are less than optimal for the management of MHPs. Given the effect of shared care on the recovery of individuals presenting with MHP,²⁷ sustained efforts in the area of policy making and at the organizational and professional levels must be deployed, together with multifaceted strategies for intervention,³⁰ to enhance the delivery of mental health care, particularly where chronic or complex MHPs are concerned. 

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Contributors

Dr Fleury was the lead researcher of the study. **Drs Aubé** and **Farand** were the lead co-researchers. **Dr Imboua** performed the data collection and analysis in collaboration with **Drs Fleury** and **Aubé**. All of the authors contributed to the design of the manuscript and the interpretation of the data. **Dr Fleury** wrote the manuscript. All of the authors read, commented on, and approved the final manuscript.

Competing interests

None declared

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