

Letters Correspondance

Easing the burden of mental health care

Dr Jayabarathan's editorial response¹ to the paper² "Shared Mental Health Care" by Rockman et al raises a number of valid issues.

If the health care system faces an "onslaught of adversity," then the mental health system reflects this by a lack of incentive to diagnose, treat, and manage mental illness. Funding issues are at the top of the list, which also includes a resource-depleted mental health system, poor distribution of specialists, and a lack of support for front-line practitioners.

The shared care model, currently in its infancy, is, in the narrowest sense, a method of assisting FPs to care for their patients; in a more ambitious way, it seeks to address some of Dr Jayabarathan's concerns.

Through early success, the shared care model is inspiring a movement to compensate FPs who are on the front line caring for mentally ill patients. The shared care model is evolving, guided by sensitivity to FP needs. For instance, based on FP feedback, shared care now embraces a spectrum of activity, including telephone, e-mail, and face-to-face backup for FPs. These approaches supplement actual patient contact, where a psychiatrist assesses a patient and provides ongoing support for FPs and patients. In some programs, shared care provides psychotherapists, case management, and language interpretation. Shared care schemes are also developing innovative CME formats, using traditional face-to-face sessions, in addition to teleconferencing, computer links, and the telephone.

I believe Dr Jayabarathan misunderstands the time commitment required of FPs who participate in the Collaborative Mental Health Care Network (CMHCN). Family physicians are *not* required to spend an hour consulting with a specialist mentor each week. In fact, a participating FP spends only as much or as little time as he or she wishes in consultation with a mentor.

As a variant of shared care, the Ontario College of Family Physicians' CMHCN mentoring program is just one step forward along a path of increasing access to mental health care and of easing the burden for FPs.

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References

1. Jayabarathan A. Shared mental health care. Bringing family physicians and psychiatrists together [editorial]. *Can Fam Physician* 2004;50:341-3 (Eng), 344-6 (Fr).
2. Rockman P, Salach L, Gotlib D, Cord M, Turner T. Shared mental health care. Model for supporting and mentoring family physicians. *Can Fam Physician* 2004;50:397-402.

A truly humbling experience

I imagine being a rural family doctor in Canada, feeling rather isolated and overworked in your 20-bed hospital that you share with five other colleagues. Imagine meeting another rural doctor half way around the world who tells you that her rural hospital has 500 beds, she sees 6500 patients a month, and does 6000 deliveries a year. Not only is she doing this in the middle of South Africa, she is also acting as the hospital administrator and is working with only 12 doctors who double as anesthetists and obstetricians. Spotting an advertisement for the WONCA conference in Florida this October, I was reminded of this truly humbling experience.

On a cold, snowy day in Little Current, Ont, (on Manitoulin Island), I finally finished my first PowerPoint presentation on a rural high school clinic and was ready to present it at the WONCA conference in Melbourne, Australia. Keeping up my courage and trying to keep an open mind, I arrived in Melbourne and soon found myself in the midst of learning about new initiatives in women's health, such as family doctors flying around the Australian outback seeing women who rarely get a