

Family physician–based care of patients with serious mental illness

Using a case-managed approach

Mel Krass MD PhD FCFP Jill Aichele NP-PHC MSN

According to a national survey,¹ most family physicians believe that access to psychiatric care in Canada and in Ontario is poor. Furthermore, the number of psychiatrists per capita is projected to decrease in the future. In the past, patients with serious mental health conditions were often able to identify with having personal psychiatrists. Today it is more often the case that a patient will see a psychiatrist for a consultation only. In this model, the psychiatrist provides the primary care provider with a comprehensive report that indicates the patient's history, diagnosis, and axis information, as well as a therapeutic recommendation that usually includes several options in the event that the first choice is not effective. In some instances, the psychiatrist sees the patient over a period of time, or for a follow-up, only if the patient is severely ill and clearly can only be managed by a qualified psychiatrist.

In the Niagara region of Ontario, there are now only a few psychiatrists who see patients long term, and almost all psychiatric referrals are for consultations only. This system can be characterized as institutional, not patient based, and episodic. This institutional, consultative model has crept into the management of those with more serious mental illness without, to our knowledge, public discussion or a clear understanding of the implications of the changes, and without the development of the needed follow-up care required to ensure that these vulnerable individuals receive the care they need. There are many local community organizations that offer excellent programs (eg, Niagara Health System's IMPACT [Integrated Mobile Program for Acute Community Treatment],² Canadian Mental Health Association Niagara's Safe Bed Program,³ Pathstone Mental Health's Crisis Services⁴) but these organizations often function in isolation and do not coordinate with primary care providers. The patients often lack advocates, and barriers are common for accessibility, medication management, and other elements of care. This situation is not uncommon across the province of Ontario or throughout the rest of Canada. There is substantial evidence that collaborative models that are based in primary care settings work very well in treating mental health

conditions.⁵⁻⁷ In fact, previously, the goal has been to move patients away from institutional care to patient-based, more comprehensive, and holistic care, as patients with serious mental illness often have multiple comorbidities, including addictions and physical illnesses, as well as family and social problems, such as poverty or housing issues.

Family practice–based, case-managed care

Family practice–based care for those with more common and less serious and disabling mental health problems is now a common feature of group practices including, but not limited to, family health teams (FHTs), community health centres, and family practice groups. The effectiveness of this approach has been well studied⁵⁻⁷ and is described as a collaborative model. However, locating treatment of more serious mental illness in family physicians' offices is not widely instituted. The advantages for patients, if successfully implemented, are improving accessibility, providing a location that is non-institutional and comfortable, and allowing for a more comprehensive and integrated approach. This model also improves collaboration between psychiatrists and primary care providers, and integration of mental health and primary care can also lead to better and more efficient deployment of resources. An article published by the Canadian Mental Health Association highlights that severe mental illness could be managed in a chronic disease management framework using a comprehensive holistic approach.⁸

In 2002 to 2003, the federal government offered Canada-wide grants for innovative approaches to mental health care and addiction, which was spurred by the *Out of the Shadows at Last* report on mental health by the Senate Committee on Social Affairs, Science and Technology.⁹ The Niagara Medical Group Family Health Team was successful in obtaining a grant to study and implement a family practice–based, holistic, case-managed approach to the treatment of patients with more serious mental illness within our practice. This group is located in Niagara Falls, Ont, and comprises 9 family physicians, 3 nurse practitioners (NPs), 3 counselors, 6 registered nurses, and a visiting psychiatrist, as well as diabetic, respiratory, and hypertension programs. In 2006 this program was approved by the Ontario Ministry of Health and Long-Term Care as a permanent program within our practice.

Patients are referred to our full-time case manager (an NP) by their family physicians, based on the serious nature and disabling degree of their mental illness.

This article has been peer reviewed.
Can Fam Physician 2016;62:956-7

Cet article se trouve aussi en français à la page 969.

Approximately 80% of our patients in the program are unable to work and most are supported financially by some form of disability pension. Ages range from 18 to 80, and the average age is 45. Currently, 6% of patients have schizophrenia, 51% have major depressive disorder, 15% have bipolar or bipolar affective disorder, 15% have severe anxiety disorders, and 30% have multiple diagnoses. All the patients will have been diagnosed previously; however, at times the diagnosis might be reviewed with assistance from our visiting psychiatrist.

Mental illness is considered as a chronic disease, and treatment and prevention is based on this approach. The NP case manager works with our FHT's psychiatrist, family physicians, NPs, and psychotherapists, as well as community psychiatrists and involved community agencies. In our holistic approach, the case manager manages patients' physical issues, social issues (eg, housing), and mental health care; acts as a liaison with community agencies; and advocates for access to provincial and federal programs. The expanded role of the family NP is ideally suited to the collaborative management of these complex patients, as they are able to manage patients independently, reassessing and modifying treatment regimens and consulting with appropriate providers as needed. This program has been in place now for more than 10 years, and the case manager helps at least 175 patients at any given time. Patients who have shown a marked improvement might be referred back to their family physicians for care so that new patients can be admitted to the program. Patients who are very ill and unstable will usually be stabilized through referral to institutional psychiatrists or teams before admission to the program. Where behavioural approaches (eg, cognitive-behavioural therapy) might be helpful, patients might be referred to our psychotherapists, and if treatment or diagnosis complications occur, we refer patients to either our visiting psychiatrist internally or, if appropriate, an outside psychiatrist. If health issues occur that are best managed by a medical specialist, the case manager might refer to a specialist outside the practice (internist, surgeon, diabetes specialist, etc). Home assessments are common, as some patients are housebound or require investigation of the home environment. The patient's family physician is kept informed through our electronic medical record system or by corridor consultations. One physician is designated as responsible to follow up with the case manager and staff. Patient satisfaction surveys and informal discussions with staff members revealed that this program was viewed quite favourably.

Advantages to this approach

It is our contention that this approach is very effective in providing excellent mental health and holistic care for our patients with serious mental illness. This is endorsed by those patients treated within the program,

as they have been provided continuity of care within the FHT and have become more confident as active participants in comanaging their chronic illness. In the initial phase of the program while it was still a pilot project, we found that fewer patients within the program needed emergency department care or were admitted to the local department of psychiatry in the first year, as compared with the year before. In addition, this arrangement of care does allow for the better implementation of recommendations from institutional psychiatrists and coordination with the FHT's family physicians. This is critically required, as the care for patients with serious mental illness is becoming, unfortunately, more fragmented than ever before.

The co-location of staff members with mental health programs is very powerful and efficient, but other arrangements using a primary care-based, case-managed model are possible, and even a system where the case manager travels to the family physician's office to see patients is conceivable. Comprehensive and accessible patient-based care is essential to the well-being of our patients with serious mental illness.

Dr Krass is a practising family physician and **Ms Aichele** is a nurse practitioner and case manager, both at the Niagara Medical Group Family Health Team in Niagara Falls, Ont.

Competing interests

None declared

Correspondence

Dr Mel Krass; e-mail mkrass1@cogeco.ca

The opinions expressed in commentaries are those of the authors. Publication does not imply endorsement by the College of Family Physicians of Canada.

References

- Buske L. *Psychiatry—a recent profile of the profession*. Ottawa, ON: Canadian Collaborative Centre for Physician Resources, Canadian Medical Association; 2012. Available from: www.cma.ca/Assets/assets-library/document/en/advocacy/25-Psychiatry-e.pdf. Accessed 2016 Oct 21.
- Niagara Health System [website]. *Mental health and addictions*. St Catharines, ON: Niagara Health System; 2016. Available from: www.niagarahealth.on.ca/en/mental-health-and-addictions. Accessed 2016 Oct 21.
- Canadian Mental Health Association Niagara [website]. *Safe beds*. St Catharines, ON: Canadian Mental Health Association Niagara; 2016. Available from: <http://cmhaniagara.ca/safebeds/>. Accessed 2016 Oct 21.
- Pathstone Mental Health [website]. *Crisis services*. Thorold, ON: Pathstone Mental Health. Available from: www.pathstonementalhealth.ca/services/crisis. Accessed 2016 Oct 21.
- Kates N, Mazowita G, Lemire F, Jayabarathan A, Bland R, Selby P, et al. *The evolution of collaborative mental health care in Canada: a shared vision for the future*. Ottawa, ON: Canadian Psychiatric Association; 2011. Available from: www.cfp.ca/uploadedFiles/Collaborative%20mental%20health%20care-2011-49-web-FIN-EN.pdf. Accessed 2016 Oct 21.
- Kates N, Craven MA, Crustolo AM, Nikolaou L, Allen C, Farrar S. Sharing care: the psychiatrist in the family physician's office. *Can J Psychiatry* 1997;42(9):960-5.
- Woltmann E, Grogan-Kaylor A, Perron B, Georges H, Kilbourne AM, Bauer MS. Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. *Am J Psychiatry* 2012;169(8):790-804.
- Canadian Mental Health Association [website]. *What is the fit between mental health, mental illness and Ontario's approach to chronic disease prevention and management?* Toronto, ON: Canadian Mental Health Association; 2016. Available from: http://ontario.cmha.ca/public_policy/what-is-the-fit-between-mental-health-mental-illness-and-ontarios-approach-to-chronic-disease-prevention-and-management/. Accessed 2016 Oct 21.
- Standing Senate Committee on Social Affairs, Science and Technology. *Out of the shadows at last. Transforming mental health, mental illness and addiction services in Canada*. Ottawa, ON: Parliament of Canada; 2006. Available from: www.parl.gc.ca/Content/SEN/Committee/391/soci/rep/rep02may06-e.htm. Accessed 2016 Oct 21.