Editor's key points

- Emerging adults (EAs) are in a unique position within the health care system. They straddle youth and adult systems, have substantial psychosocial needs, and lack a foothold in the health care system, making it difficult for FPs to treat EA mental health, resulting in FPs and EAs feeling "lost together" in a fragmented mental health care system.
- Family physicians play a particular role in EA mental health. Often, they are the default physicians while the EA waits for care from a mental health specialist, and the physicians that the patient is referred back to after specialist care. The FPs often treat the rest of the EA's family, giving them a unique contextual perspective of their patients.
- By improving their knowledge and skills, and creating family practice teams, FPs can better support mental health care for EAs.

Lost together

Experiences of family physicians with emerging adult mental health

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Abstract

Objective To explore the perceptions and experiences of FPs with emerging adult (EA) mental health to inform opportunities for improvement in EA mental health care.

Design Constructivist grounded theory methodology, including theoretical sampling and constant comparative analysis of data to synthesize results.

Setting Southwestern Ontario.

Participants Twenty practising FPs.

Methods In-depth, semistructured, in-person interviews, which were audiorecorded and transcribed verbatim.

Main findings Family physicians recognized the unique situation of EAs being between adolescence and adulthood, having heavy psychosocial needs, and lacking a connection to the health care system. Experience and confidence are needed to treat the EA population, but provision of mental health care to EAs is influenced by resources, knowledge, and communication. Family physicians noted that they are the default physician while EAs wait for specialized care, and are often the physicians that the patient is referred back to after specialized care. Often, the FP knows and treats the EA's entire family, which participants described as enabling them to understand the EA's unique context.

Conclusion Family physicians and EAs are "lost together" in a fragmented health care system. Family physicians have the unique potential to assist EAs with their mental health needs, but that is not being actualized. Family physicians can support mental health outcomes for EAs through an improvement in knowledge and skills, and through forming family practice teams.

Perdus ensemble

Expériences des médecins de famille relatives à la santé mentale des adultes émergents

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Résumé

Objectif Explorer les perceptions et les expériences des MF relatives à la santé mentale des adultes émergents (AE) afin de cerner des possibilités d'améliorer les soins de santé mentale aux AE.

Type d'étude Méthodologie de la théorisation ancrée constructiviste, y compris un échantillonnage théorique et une analyse comparative constante des données pour faire la synthèse des résultats.

Contexte Sud-ouest de l'Ontario.

Participants Vingt MF en pratique active.

Méthodes Entrevues semi-structurées en profondeur et en personne, qui ont fait l'objet d'un enregistrement sonore et d'une transcription mot pour mot.

Principales constatations Les médecins de famille ont reconnu la situation particulière des AE, qui sont entre l'adolescence et l'âge adulte, qui ont des besoins psychosociaux considérables et qui ont peu de connexions avec le système de santé. Il faut de l'expérience et de la confiance pour traiter la population des AE, mais la prestation de soins de santé mentale à des AE est influencée par les ressources, les connaissances et la communication. Les médecins de famille ont fait remarquer qu'ils sont les médecins par défaut, pendant que les AE attendent de recevoir des soins spécialisés, et souvent, on leur confie ces patients après la prestation de tels soins. Il arrive souvent que le MF connaisse et traite toute la famille de l'AE, et les participants ont décrit cette situation comme une possibilité de bien comprendre le contexte particulier de l'AE.

Conclusion Les médecins de famille et les AE sont « perdus ensemble » dans un système de soins fragmenté. Les médecins de famille ont un potentiel unique pour aider à répondre aux besoins des AE en matière de santé mentale, mais ce potentiel ne s'actualise pas. Les médecins de famille peuvent contribuer à de bons résultats en santé mentale chez les AE en améliorant leurs connaissances et leurs compétences, et en formant des équipes de pratique familiale.

Points de repère du rédacteur

- Les adultes émergents (AE) sont dans une situation unique au sein du système de santé. Ils chevauchent les systèmes pour les enfants et pour les adultes, ils ont des besoins psychosociaux considérables, et ils ne sont pas bien ancrés dans le système de santé, ce qui rend difficile pour les MF de traiter leur santé mentale. Par conséquent, les MF et les AE se sentent « perdus ensemble » dans un système de soins de santé mentale fragmenté.
- Les médecins de famille jouent un rôle particulier dans la santé mentale des AE. Souvent, ils sont les médecins par défaut pendant que les AE attendent d'être soignés par un spécialiste de la santé mentale, et on leur confie ces patients après la prestation de soins spécialisés. Souvent, les MF traitent le reste de la famille des AE, ce qui leur donne une perspective contextuelle unique sur leurs patients.
- En perfectionnant leurs connaissances et leurs compétences, et en formant des équipes de pratique familiale, les MF peuvent améliorer leur soutien aux soins de santé mentale des AE.

Mental illness is the most disabling group of disorders around the world, affecting approximately 10% to 20% of Canadian youth.[1] The Mental Health Commission of Canada[2] explored the status of mental health services for emerging adults (EAs) between the ages of 16 and 25, and found that there is limited scientific evidence on the best ways to support EAs with mental illness in this critical stage of life. Emerging adults are different than adults, and they have unique needs. Many EAs struggle to engage with health services independently, often requiring parental or caregiver involvement due to complex presentations and limited time.[3,4] Family physicians play an important role in mental health care for EAs and often act as the first contact.[5-8] Up to 40% of EAs seeking help for mental illness are seen only by FPs.[9,10] However, many EAs do not trust their FPs, perceiving them as impersonal and uncaring strangers.[11] This creates an environment that does not promote optimal mental health care for EAs.

The potential for FPs to improve EA mental health is further constrained by FPs reporting relatively low confidence levels on many issues related to EA mental health. For example, FPs reported low confidence levels on issues such as making a diagnosis (70.0%), initiating management (86.6%), assessing the child-caregiver relationship (72.0%), and distinguishing between normal and pathological behavioural problems (75.1%).[12] Family physicians might be uncomfortable making mental health diagnoses in youth[3] and treating youth with complex mental health presentations.[12] Family physicians also note other systemic limitations to provision of care, such as a scarcity of specialized youth services and limited access to existing mental health and social services, including psychiatrists, psychologists, psychotherapists, and vocational or educational supports.[13]

In the Canadian context, previous research has highlighted several systemic health care challenges, including long wait times and crisis-driven services, leading to feelings of powerlessness among youth and caregivers.[14] Providers, caregivers, and EAs agree that there is a need for delivery of services through a flexible, real-time system that emphasizes patient and caregiver engagement, youth-centric services, and recovery-oriented care across the hospital-community continuum. For example, stepped care systems and walk-in mental health clinics are gaining interest because of their flexible hours and self-referral processes.[15]

Although FPs report relatively low confidence levels on many issues related to EA mental health[12,16] and have limitations outside of their control,[13,17] they have the potential to improve mental health outcomes for EAs during this vulnerable period in life. More research is needed to understand if this potential is being actualized. The purpose of this study was to explore the perceptions of FPs on their role in the provision of mental health services to EAs to establish a deeper understanding of associated barriers to and facilitators of EA mental health care.

Methods

Study design

This study used a constructivist grounded theory approach with semistructured interview questions that asked FPs for their perceptions on and experiences with providing mental health care to EAs, and asked for feedback about opportunities for improvement in EA mental health care. The research team included an applied health services researcher (K.M.), an FP (S.H.), and an in-hospital child and adolescent psychiatrist (J.S.). The Research Ethics Board at Western University in London, Ont, approved the study.

Participant recruitment

This study used a purposive sampling method for recruiting FPs. Family physicians practising in southwestern Ontario were recruited on a voluntary basis through e-mail, referral, and word of mouth. A total of 20 FPs participated in the study.

Data collection and analysis

Data were collected using in-depth, semistructured, in-person interviews. The interviews were conducted by a single researcher (K.M.) and the questions asked about the unique mental health needs of EAs, the role of FPs in providing mental health care, the definition of effective care, the barriers to and facilitators of care, the types of care offered, the areas for additional training, the ideal health services model, the ways hospitals and community services could collaborate in the future, and any additional topics of interest. The interview guide was iteratively revised based on group discussion and initial findings. Interviews ranged from 15 to 45 minutes; they were audiorecorded and transcribed verbatim.

Data were organized and analyzed using the coding software program NVivo 11. For the first 3 interviews, all 3 researchers engaged in a line-by-line coding technique described by Charmaz,[18] which allows researchers to interact and study each fragment of the data to identify areas of further exploration, make comparisons, and suggest emerging links. Subsequently, the team convened to reach a consensus on coding results to ensure there was agreement on initial findings. The remaining interviews were coded by K.M. Once most of the interviews were coded, the team met to engage in focused coding, a method that identifies recurring codes in a data set. From these focused codes, a theory was developed using Charmaz's[18] key elements of theory development, which describes theory development as something that accounts for what happens, how it happens, and why it happens. Data were simultaneously collected and analyzed, and data collection continued until theoretical sufficiency was reached.[19]

Findings

Shared experience of challenges

Participants recognized the numerous challenges facing their young patients and described their own struggles as FPs practising within a challenging mental health care system. For example, participants emphasized that EAs are in the unique situation of being between child and adult systems of care: "They're trying to learn to be adults. They are not children and they are not totally fully matured adults, depending on their maturity and physical as well as mental. Their needs are different." (FP-16)

Participants also described the complex and unique psychosocial needs of EAs. One participant indicated that "a fair amount ... [of] more psychosocial support" is what EAs need (FP-4), while another participant stated that they struggle with delineating between actual mental health issues and a kind of "existential despair":

> I have watched a trend towards parents and schools sending children in to see me because they have a mental health issue. When a lot of times [when I see the children and youth] I'm not sure whether I'm their mother, the grandmother, their neighbour next door. And I'm offering a lot of advice with what I would consider to be not true mental health diagnoses, but more of an existential despair. (FP-8)

Participants also described several challenges related to mental health care for their EA patients, such as gaps in FP knowledge related to the assessment, treatment, and availability of community resources for EA mental health:

> I barely know what resources [there are] and I've been in practice for 5 years and training here for 6 years. Doctors just starting here [at the clinic as new graduates] ... their patients have no way of knowing what's available. And we're often the point of contact when they're entering that mental health system; we're their prime contact. If family docs don't know literally the system inside and out, their patients are going to get the short end of the stick in terms of access. (FP-18)

A further challenge to FPs was a disconnect in timely, high-quality communication with other sectors (such as education), health care organizations, and specialists:

> I think there's a bit of a disconnect in terms of timely communication getting to family doctors. I just had an example yesterday of a patient that had been admitted to adult psychiatry from [3 months ago] until yesterday and the patient showed up in my office yesterday needing a prescription of her medication, stating that she had been discharged. And there had been no communication to me that that had happened, what changes had happened ... I mean, this patient arrives at my office with no information on what's happened and I'm just supposed to take over the care and I think that that's rather unfair. (FP-11)

Family physicians noted that the lack of coordination and communication within an already fragmented health care system contributes to disconnection, frustration, and a shared experience of feeling lost.

Unique position to address challenges

Family physicians recognize that they are often the first contact for mental health concerns, as many EAs lack a foothold in the system. A participant noted that EA patients are unique because "they don't tend to come to family doctors very much" (FP-17). Another participant stated that they see fewer youths now than in the past: "And we don't do health in youth ... we don't see [them] as often anymore .... So, we don't see that population if they are healthy with no concerns as much as we did even 10 years ago" (FP-12).

Participants considered FPs as being a safety net for EA patients after they complete an episode of care with a mental health specialist, such as a psychiatrist:

> Very often what psychiatry ends up being is ... the consultation service .... They'll go in, they'll have diagnostic clarification, they'll get treatment initiation for a couple of visits, and then they're referred back to the family physician for ongoing management from there. (FP-10)

Participants described the long-term relationship between EAs and FPs as one in which the FP is the default physician and treats both EAs and their family members:

> I think one of the advantages that we have as family doctors [is that] with a lot of our patients, especially our youth, because we have families, that we know them and we know their family context ... so that allows [us] to kind of really understand the context of how that youth is presenting. (FP-12)

Participants also suggested that team-based care could improve outcomes for EAs within primary care. Many participants struggled with the variation in resources that were available for different settings. Some operated as solo practitioners; others operated within a group of FPs with limited, occasional resources. Other FPs had access to social workers and nurses who specialized in mental health or pediatric mental health. In some practices, psychologists and psychiatrists could provide consultation. An FP moving from solo practice to a family health team describes this difference:

> Here are the things that we absolutely need ... a full-time social worker ... once a month [a] child

> psychologist and once a month [a] psychiatrist. So, not needing the more pricey items but that social work[er] that [provides] crisis counseling for somebody .... Kind of a unique perspective I bring because we are coming from a place where we have nothing right now [in terms of allied health care professionals at the clinic]. (FP-18)

By working with mental health professionals, FPs had more knowledge of available resources for EA patients that they were unaware of previously. Mental health professionals also provided specialized treatments outside the FP scope of practice:

> We have social workers and they offer cognitive-behavioural therapy. They offer other supportive listening and stress management strategies .... We also have a mental health nurse [who] provides counseling and she provides also great supportive resources. (FP-12)

Working with other mental health care providers was seen as an important resource for FPs. One participant stated that the psychologist was "incredibly helpful" in providing "diagnostic clarification" and support with therapeutics (FP-3), while another stated they were fortunate to have access to both a child psychiatrist and an adult psychiatrist to "see referrals in a fairly timely manner" (FP-11).

Discussion

Family physicians indicated they feel overwhelmed in a complex and fragmented health care system when attempting to address mental health concerns for EAs. Participants described unique roles, needs, and potential for improving EA mental health outcomes. Family physicians recognized their distinctive role in treating EAs, and noted the variations in both their experience and their confidence related to access to specialized resources, knowledge, and communication with mental health specialists. Moreover, FPs highlighted the unique developmental situation of EAs as being between youth and adult systems, having heavy psychosocial needs, and generally lacking a foothold in the health care system. Our participants emphasized the FP role as the default physician for care while the EA is waiting for specialized care, and the physician that the patient is discharged to after care by a mental health specialist. In addition, the FP often knows and treats the whole family, which can make care delivery more complex and challenging. Knowing the entire family can help to understand the EA's context, but it can also produce assumptions that act as barriers to helping the EA with his or her mental health concerns. Family physicians also act as front-line care workers, providing care in settings such as walk-in clinics, student health centres, and mental health and addictions centres; in these settings, longitudinal relationships can still be fostered.

Previous research[2-8] has described challenges related to FPs and EA mental health treatment. This study shows that EAs are a unique population when it comes to accessing care for mental health concerns, and highlights the FP role in assessing care and FPs' concerns about competency.[12,13] This study emphasizes the need for improving resources for youth mental health and access to mental health professionals.[14,20] Researchers have suggested interventions related to resources,[21] such as implementing team-based care, improving FP knowledge of available resources, and using communication materials that focus on education.[20-22]

Our findings are generally consistent with known gaps related to identifying, addressing, and responding to EA mental health needs. There are several authors who have proposed solutions for the gaps identified in our study. For example, resource constraints can be mitigated through team-based care, knowledge gaps through educational interventions,[23] and fragmentation through system integration.[24]

This study underscores how the shared experience of helplessness between EAs and their FPs reflects the unique relationship between youth and FPs, especially when compared with other physicians or mental health professionals. We suggest that FPs are not only in a unique structural position to assist EAs, but they are in a unique relational position, too. By recognizing their limitations of access, communication with mental health specialists, and knowledge, FPs have an opportunity to acknowledge their own vulnerability with EA patients to build a relationship of mutual trust as they embark on a journey of care together.

In addition, implementing a team approach within the FP practice—including the use of social workers, nurses, psychologists, and psychiatrists—might facilitate early intervention and allow EAs to obtain treatment in the community without having to access hospital care. Future research and knowledge translation might benefit from surveying nonphysician professionals who work in family practice settings, and gathering EA perspectives on working with FPs directly to navigate the health care system.

Limitations

While the breadth and variety of the sample population allowed for an in-depth exploration of mental health services for EAs as perceived by FPs, the participants in this study were all from the same relatively small geographic area in Canada. Another limitation was that the FP sample was largely made up of individuals with academic appointments, despite efforts to also recruit FPs not connected to an academic centre.

Conclusion

Our effort to explore FP perceptions of their role in providing mental health services to EAs found that FPs believe they share a perception of "being lost together" with

their EA patients in a challenging, fragmented mental health system. From this study, we can propose that FPs can better support EA mental health by improving their knowledge and skills, and implementing family practice teams. This will allow FPs to skillfully navigate the complex health care system alongside their EA patients.

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Contributors
All authors contributed to the concept and design of this study; data gathering, analysis, and interpretations; and preparing the manuscript for submission.

Competing interests
None declared

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