



Canadian Psychiatric Association
Association des psychiatres du Canada



The College of
Family Physicians
of Canada

Le Collège des
médecins de famille
du Canada

Shared Mental Health Care in Canada

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This position paper was reviewed and delisted as an official position of the Canadian Psychiatric Association on September 17, 2010. It is being made available for historical purposes only. The paper was originally developed by the Joint Working Group of the Canadian Psychiatric Association and The College of Family Physicians of Canada and approved by the CPA's Board of Directors on October 4, 1996.

EXECUTIVE SUMMARY

The family physician already plays an extensive role as a provider of mental health care in almost every community in Canada. In theory, the family physician and the psychiatrist are natural partners in the mental health care system. While neither may be able to meet every need of a patient with a mental disorder, each can offer complementary services, which enables them to play a key role at different stages of an episode of illness and the subsequent period of recovery. Too often, however, family physicians and psychiatrists fail to establish the collaborative working relationships that would strengthen the role of the family physician, enhance the consultative role of the psychiatrist, and improve the quality of care their patients receive.

The need to improve these relationships, a key step towards a better-integrated and more efficient health care system, becomes even more pressing in the current climate of rapid change in the organization of health care in Canadian provinces. Almost every province is now involved in reforming both its mental health care and primary care systems—often with minimal coordination of these processes. In addition, many communities across the country are witnessing rapid and often sweeping realignments of services, with an emphasis on shifting resources from hospital to community settings.

These changes are likely to accentuate the role of primary care as the cornerstone of the health care system and will be accompanied by significant changes in the delivery of both secondary and tertiary care. This will require new collaborative partnerships and models of care delivery between family physicians and specialists, including psychiatrists.

Recognizing the need to respond to these issues, the College of Family Physicians of Canada (CFPC) and the Canadian Psychiatric Association (CPA) set up a working group to prepare a report that would highlight the advantages of greater collaboration between family physicians and psychiatrists and its benefits for both patients and providers and describe a range of practitioner behaviours, practices, and policies which could contribute to collaborative mental health care.

It was envisaged that such a report would encourage the implementation of shared mental health care in clinical practice and describe the ways in which it could enhance the current activities of family physicians and psychiatrists. It would also emphasize the need for appropriate preparation of psychiatrists and family physicians to enable them to work effectively in a shared care model. Although this report limits its comments to shared care between psychiatrists and family physicians, many of the issues raised are likely to apply to all mental health and primary care providers.

The committee was aware of the wide variation in resource availability and organization of services across the country. It solicited input from psychiatrists and family physicians, their professional associations and departments of family medicine and psychiatry across Canada, and has drawn on a number of planning documents already prepared by provincial and national organizations.

In preparing this report, rather than presenting a single model, we have outlined the key principles that should guide collaborative activities between family physicians and psychiatrists. We then suggest 3 broad strategies—1) improving communication; 2) building new linkages

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between family physicians and psychiatrists and psychiatric services; and 3) integrating psychiatrists and psychiatric services within primary care settings—that can lead to the successful implementation of these principles and enhance collaborative care.

These strategies can be adapted to any community, especially more isolated, underserved communities. Many of the suggestions outlined, particularly those for improving communication, require relatively small adjustments on the part of practitioners but can lead to marked improvements in working relationships. Shared mental health care is not an alternate style of practice but rather a component of care that can become a valuable extension of the current clinical practices of the psychiatrist and family physician, broadening and enriching the care that each is able to offer.

The audience for this report is not, however, restricted to front-line practitioners. The successful implementation of models of shared mental health care also requires changes within other parts of the health care system and the active support of professional associations of family physicians and psychiatrists, of academic departments of family medicine and psychiatry, and of bodies responsible for health service planning and the setting of policy at local, provincial, and national levels.

It also challenges policy makers and planners to find ways to integrate the concurrent reforms of primary care and mental health taking place in each Canadian province and to address the policy and planning implications of shared mental health care.

A number of collaborative projects have already been established across Canada, and more are likely to follow. As new projects are set up, it is important that they be evaluated to enable us to learn about the benefits and any possible drawbacks of shared mental health care and to use the findings to enhance future projects.

The mandate of the CFPC-CPA committee was to achieve consensus on these issues among psychiatrists and family physicians. Consequently, this report does not address similar issues pertaining to other professional groups. Many individuals from a variety of professional backgrounds play key roles in delivering mental health care in both primary care and mental health service settings. The principles and practices outlined in this report, however, may be applicable to interactions between all primary care providers and mental health service personnel. Further discussion among these groups of the possibilities and implications of shared mental health care is clearly desirable.

The successful implementation of shared mental health care is likely to strengthen communication, collaboration, and mutual support between psychiatrists and family physicians and lead to improved access to psychiatric consultation and treatment care for Canadians. It will also facilitate a more efficient use of available resources and lead to a less fragmented, better-integrated health care system.

BACKGROUND

Family physicians are in an excellent position to provide mental health care for their patients (1). Eighty-three percent of Canadians visit their family physician each year (2), and the family physician is often the first point of contact for an individual with a mental health problem (3). Over 50% of people with mental disorders who receive mental health care receive it from their family physician, often without the involvement of any other provider (4). To be able to provide optimal mental health care, however, the family physician needs to be supported by and to work closely with psychiatrists and psychiatric services (5–11).

Four management patterns can be described for the mental health problems of patients with mental disorders who are seen by their family physician. These are: 1) management by the family physician alone; 2) ongoing management by the family physician with additional advice or support from a psychiatrist or other mental health care provider; 3) referral to a psychiatrist or psychiatric service for a consultation; and 4) referral to a psychiatrist or psychiatric service for continuing care. In each of these scenarios, a positive working relationship with a psychiatrist or mental health service can assist the family physician in detecting and treating a problem and enhance the quality of care a patient receives.

Too often, however, family physicians and psychiatrists fail to establish the collaborative working relationships that would strengthen the role of the family physician, enhance the consultative role of the psychiatrist, and improve the quality of care their patients receive (11,12). This is unfortunate because family physicians and psychiatrists would make natural partners in the mental health care system, offering complementary services. Neither may be able to meet every need of a patient with a mental disorder, but each can play a key role at different stages of an episode of illness and the subsequent period of recovery.

Collaborative care between family physicians and psychiatrists is a critical step toward improving the mental health care received by Canadians. It enriches the care each can offer and facilitates a biopsychosocial approach to a comprehensive range of mental health problems and disorders, enhancing the well-being of individuals and communities. It also encourages a more efficient and effective use of increasingly limited resources and can heighten the skills and satisfaction of family physicians and psychiatrists alike.

1.1 Purposes of this Document

The CFPC and the CPA recognized the importance of collaborative care and set up a working group to prepare a report that would: 1) highlight the advantages of greater collaboration between family physicians and psychiatrists and its benefits for both patients and providers; 2) describe a range of practitioner behaviours, practices, and policies

which can contribute to collaborative mental health care; 3) encourage the implementation of shared mental health care in clinical practice; 4) emphasize the need for appropriate preparation of psychiatrists and family physicians to enable them to work effectively in a shared care model; and 5) encourage policy makers and planners to find ways to integrate the concurrent reforms of primary care and mental health taking place in each Canadian province and to address the policy and planning implications of shared mental health care.

It is anticipated that the implementation of the recommendations in this document will lead to a strengthening of links between psychiatrists and family physicians in both clinical practice and training which will benefit providers, patients and the health system as a whole. Some of the potential benefits are as follows:

For Patients

- enhanced quality of mental health care received
- improved access to psychiatric consultation when required
- improved access to psychiatric services when required

For Providers

- increased skill and comfort on the part of family physicians in managing mental health problems
- increased effectiveness on the part of psychiatrists as consultants and supports to family physicians
- mutual support when managing complex mental health problems.

For the Health Care System

- a more efficient and effective use of available resources
- models that will enhance the mental health care provided for individuals living in more isolated communities
- elimination of some of the barriers that prevent better integration of mental health and primary care reform
- opportunities for collaborative projects that lead to the prevention or early detection of mental health problems.

The mandate of the CFPC-CPA committee was to achieve consensus on these issues among psychiatrists and family physicians. For that reason, this document does not address issues pertaining to other professional groups. Many other individuals from a variety of professional backgrounds play key roles in delivering mental health care in both primary care and mental health services. The principles and practices outlined in this report, however, may be applicable to interactions between all primary care providers and mental health service personnel. Further discussion among these groups of the possibilities and implications of shared mental health care is clearly desirable.

THE CURRENT SITUATION

2.1 Mental Health Problems in Family Medicine

i. The Burden of Illness

Approximately a third of all family practice patients have identifiable mental health problems (13–15), and 25% of all patients who visit their family physician have a diagnosable mental disorder (16–18). These figures may be even higher for teenagers (3) and the elderly (19). The family physician is the first and often the only contact with a mental health care provider for individuals with mental health problems or psychiatric disorders. These problems are often enduring, and many are severe and disabling (20). One American study found depression to be as disabling a disease as 8 common physical disorders, such as cardiovascular disease or rheumatoid arthritis, in terms of the cost to the individual and the community (21).

ii. Comorbid Problems

Many individuals with physical illnesses treated in primary care experience emotional symptoms, either as a part of or in reaction to the presence of the medical condition. Effective treatment of these symptoms can reduce morbidity and decrease utilization of other health services (22–25). The family physician is also in a good position to treat the medical problems of individuals with a psychiatric disorder, which have a higher risk of not being treated, to recognize comorbid drug or alcohol dependency, and to initiate treatment or referral at an early stage of an episode of illness.

2.2 The Role of the Family Physician

Ninety-seven percent of Canadians have a family physician, and 83% will visit their family physician during the course of a year (2). A recent study of the practices of family physicians in each of Ontario's health planning regions (12) confirmed that family physicians spend a large proportion of their time diagnosing and treating individuals who have emotional or psychiatric problems. In addition, in many parts of the country, family physicians also treat individuals with mental health problems during inpatient admissions. The family physicians in this study emphasized the broad range of mental health problems they see, the high prevalence of these problems, the frequent overlap of physical and emotional symptoms, and the importance of the family physician as a key provider of mental health care. Family physicians indicated they dealt with a large number of mental health problems in individuals of all ages, including many with serious mental illnesses, and they stressed the importance of and need for a well-integrated biopsychosocial approach to all aspects of a patient's care.

The family physician has a number of natural advantages as a provider of mental health care. He or she has a continuing relationship with the patient (48% of Canadians have had the same family physician for at least 10 years [2]),

has knowledge of the patient's family and of the physical and social environment in which the patient lives, and has an understanding of coexisting general medical problems and available community resources, including other health providers who are involved with the patient (for example, other medical specialists or community nursing agencies). These advantages put the family physician in an excellent position to identify and treat mental health problems at an early stage, prevent relapse after an episode has been successfully treated, assist individuals and families in maintaining good mental health, coordinate the health and mental health services an individual may require, detect and treat the medical problems of individuals with mental disorders and encourage healthy lifestyle choices, and provide support and information for the families of individuals with a serious mental or physical illness.

2.3 The Role of the Psychiatrist

Increasingly, psychiatrists are being asked to function as consultants and as members of multidisciplinary teams. They are able to provide comprehensive biopsychosocial assessments and formulations, play an active role in developing treatment plans, especially regarding the use of psychotropic medication, provide ongoing treatment or rehabilitation where appropriate, assist family physicians and other medical specialists in the management of individuals with comorbid medical disorders, and facilitate referrals to more specialized psychiatric services (9,10,26). These new roles will also demand greater integration within the medical community and an enhancement of medical and diagnostic skills. Another important activity for the psychiatrist is providing indirect (patient not seen) consultation to other providers of mental health care that may be patient-, staff-, or program-centred (26).

One emerging challenge facing psychiatry is a changing pattern of consultation to other medical specialties. Shorter lengths of stay in medical and surgical units in general hospitals are leading to a greater demand for outpatient rather than inpatient consultation. This trend makes it more likely that the psychiatrist will be consulting to the family physician as well as or instead of another medical specialist. This focus on consultation and collaboration with referral sources also highlights the potential of the psychiatrist as an educator (10,26).

While these activities should complement and reinforce the mental health care activities family physicians can offer, most psychiatrists have little contact with family physicians, and few spend any time working directly with family physicians.

2.4 Health Care System Reform

i. Mental Health Reform

Over the last 5 years, most Canadian provinces have embarked upon reform of their mental health systems.

These plans have a number of common goals including the more efficient use of resources, better coordination of services, and a shift to more community-based care. Most mental health reform planning documents overlook the role of the family physician as a key mental health care provider and provide minimal commentary on the role of the psychiatrist within the reformed mental health system. These oversights are significant and potentially costly. Without a clear understanding of the roles of the psychiatrist and the family physician, mental health reform is likely to result in a poorly coordinated system, fragmented care, and less efficient services.

ii. Primary Care Reform

Canadian provinces are also in the midst of reforming primary care services, a process that has been catalyzed by a joint statement prepared by the ministers of health of the provinces and territories (27) which envisages primary care as the cornerstone of the health care system, consistent with the vision for health care espoused by the World Health Organization (8).

This renewed emphasis on primary care makes the need for new models of collaboration between family physicians and specialists, highlighted in a joint document on consultative care produced by the CFPC and the Royal College of Physicians and Surgeons of Canada (RCPSC) in 1993, even more pressing (28). It also opens up many possible avenues for better integration of specialized services (including psychiatric services) within primary care settings (29).

The lack of coordination between primary care reform and mental health reform—one of which highlights the role of the family physician as a key mental health care provider (primary care reform), the other which virtually ignores this role (mental health reform)—needs to be addressed. A more collaborative planning process is clearly required if the resulting health care system is to be coherent, efficient, and cost-effective.

iii. Long-Term Care Reform

Individuals requiring long-term care, many of whom are elderly, often present with complex medical and psychiatric needs. Although many long-term care planning processes have overlooked the need for physical and medical treatments, the care of an older individual with comorbid medical and psychiatric problems represents the quintessential situation where the psychiatrist and family physician need to be able to work collaboratively.

2.5 Service Realignments and Cost Constraints

Reductions in funding for hospital services and a shift in resources from hospitals to the community are having an impact on both family physicians and psychiatrists. Many procedures and treatments that used to be conducted in hospitals or clinics are now being "off-loaded" to family physicians, who are being expected to take on additional

patient care responsibilities, often with few additional resources or supports. Reduced access to inpatient psychiatric beds and pressures to shorten lengths of stay have also resulted in psychiatric clinics and family physicians managing individuals who have more acute and less stable mental health problems.

The expanding role of the family physician in delivering mental health care can be assisted by rapid access to specialized services and supports that complement and reinforce the care the family physician provides. At times of cost constraint, collaboration could lead to better outcomes and quality of life for consumers, a more efficient use of resources and increased satisfaction for providers.

2.6 Underserved Domains

Most provinces have identified populations that do not receive adequate mental health care. These include both geographic areas, such as isolated communities, and specific target populations like the elderly or certain cultural groups.

i. Underserved Communities

Most Canadian provinces face difficulties in providing specialized health services to individuals living in more isolated communities. While recruitment of specialists to work in these areas will remain an important component of any overall solution, there is also a need to develop alternate models of care that are based in primary care and use psychiatric resources as efficiently as possible, providing direct and indirect consultation, teaching, and skill development as well as ongoing care.

ii. Underserved Populations

While a number of groups in our communities underutilize potentially beneficial mental health services, many of these individuals receive general health services from family physicians. Although family physicians are in an excellent position to provide mental health care to these individuals and to link them with other psychiatric and community services, they frequently have difficulty accessing psychiatric backup, advice, or consultation. As a result, many individuals in these groups fail to receive needed services.

2.7 Use of Mental Health Services in Primary Care

The health care system encourages individuals to see their family physician as the first point of contact (3), something that will be reinforced if rostering is introduced on a large scale (27). Most Canadians already have an enduring relationship with a single family physician, although they may not always consider seeking mental health care from their family physician. A number of studies, including the recent Edmonton Household Survey, found that only 50% of individuals who were depressed would raise this with

their family physician, and less than 10% of individuals with an addiction problem would talk about the problem unless specifically asked (30). There is clearly a need for innovative public education approaches that will increase the likelihood that such problems will be brought to the family physician's attention (31,32).

PROBLEMS IN THE PRESENT RELATIONSHIP BETWEEN PSYCHIATRY AND FAMILY MEDICINE

Recent studies of family physicians in Canada and other jurisdictions have found similar and frequently occurring problems in the relationship between psychiatry and family medicine (10,12,33,34). Some of these reflect broader systems issues, such as the pace and demands of primary care, methods of remuneration, and poor coordination of planning within provincial ministries of health.

More specific problems that have been identified include a lack of communication between psychiatrists and family physicians caring for the same individual, difficulty on the part of family physicians in accessing consultation and treatment services for their patients, and a lack of mutual respect and support for the contributions that providers from different disciplines can make in delivering mental health care (11,12,35,36). These problems can be summarized under 3 general headings: difficulty with access, poor communication, and lack of personal contact.

3.1 Difficulty with Access

Family physicians are frequently frustrated by the difficulties they encounter when trying to access psychiatric consultative or treatment services and by the seemingly unnecessary obstacles in referral procedures, especially when they perceive the problem to be urgent. Psychiatric services are often perceived as being not user-friendly, with arbitrary exclusion criteria that make apparently artificial and inconsistent divisions between psychiatric and psychosocial problems and with catchmenting boundaries that may conflict with a family physician's hospital affiliation. Family physicians have identified that most of these problems do not occur to the same degree with other medical and surgical specialties.

By the same token, psychiatrists and other mental health care providers are sometimes faced with a reluctance on the part of the family physician to take responsibility for the continuing mental health care of a patient once an acute episode has been stabilized. The reasons for such reluctance may be multiple, including the physician's level of comfort with, interest in, and knowledge of such problems, a lack of support from the psychiatric system, and financial disincentives.

3.2 Problems in Communication

There are several frequently cited problems in communication between family medicine and psychiatry. First, family physicians are often not informed about the progress of a patient after he or she has been assessed by a psychiatrist or psychiatric service or about treatment changes, secondary referrals to other specialists, or discharge plans. Psychiatric services do not always consider the transmittal of this information to be a routine and essential part of their management. In a similar vein, at the time of referral, psychiatrists and psychiatric services are not always provided with sufficient information by the family physician to make appropriate decisions about treatment goals and initial management. Third, family physicians are often unclear about the inclusion and exclusion criteria and intake policies of psychiatric services. Fourth, goals and expectations for a referral are not always discussed and clarified when a referral is made. This can create confusion as to which provider is responsible for which aspects of a patient's care. Fifth, there is often a delay on the part of psychiatrists or psychiatric services in providing assessment and discharge notes to referring family physicians. A sixth problem of communication is that family physicians and psychiatrists are often difficult to reach by phone, especially for nonphysician health care providers.

Because many psychiatric services are organized into teams in which psychiatrists and other providers work together, the family physician may be dealing with 3 or 4 individuals who are involved with a single patient. This too can fragment communication. In addition, family physicians may not understand their responsibilities under mental health legislation and the limits such legislation can impose. These can be a source of great frustration. Finally, in certain situations, confidentiality issues can make it difficult for providers to exchange information.

3.3 Lack of Personal Contact

Family physicians often have never met the psychiatrist to whom they are referring and do not come into contact with him or her on a regular basis through hospital or other activities. This lack of personal contact makes it less likely that mutual cases can be discussed and works against family physicians and psychiatrists learning about each other's skills, strengths, and interests. In the worst extreme, the relationship between psychiatry and family medicine is characterized by stereotypic misconceptions and a lack of respect for the role that the other discipline can and does play in providing mental health care.

SHARED MENTAL HEALTH CARE

These findings suggest a need for a significant reappraisal of the relationship between family physicians and psychiatrists. Alternative models of collaboration that are more collegial and interactive, with clearly defined roles and

responsibilities for both family physician and psychiatrist, are required to promote an integrated and holistic approach to physical and mental health problems and ensure greater continuity of care. This can be achieved if the psychiatrist and family physician work collaboratively to share the delivery of mental health care (37–49).

Shared care is a process of collaboration between the family physician and the psychiatrist that enables the responsibilities of care to be apportioned according to the treatment needs of the patient at different points in time in the course of a mental health problem and the respective skills of the family physician and psychiatrist. Rather than being seen as a separate style of practice, shared care can become a valuable extension of the clinical practice of psychiatrists and family physicians and an integral part of the treatment of any individual with a mental disorder whenever a family physician requires additional input from a psychiatrist or psychiatric service.

Shared care covers a broad spectrum of collaborative treatment possibilities, and no single model or approach will be applicable in every community or situation. At the very least, it involves clear, helpful, 2-way communication between the family physician and psychiatrist or psychiatric service. At the other end of the spectrum, it may involve psychiatrists and/or other mental health workers providing consultation and treatment in the family physician's office and developing collaborative management plans with the family physician. Functions that lend themselves well to shared care include early detection and the initiation of treatment, ongoing monitoring, crisis intervention, relapse prevention, and mental health education. Shared care should lead to improved patient outcomes and quality of life; a more efficient use of resources; optimal use of the time and skills of family physicians, psychiatrists, and other providers; improvement in the ability of family physicians to access timely and appropriate psychiatric consultation and backup; and enhanced morale and reduced frustration on the part of providers.

4.1 Principles to Guide Shared Mental Health Care

Shared mental health care should be based on a consistent set of principles.

- Family physicians and psychiatrists are part of a single mental health care delivery system.
- The family physician has an enduring relationship with a patient that the psychiatrist should aim to support and strengthen.
- No single provider can be expected to have the time and skills to provide all the necessary care a patient may require.
- Professional relationships must be based upon mutual respect and trust.
- Roles and activities of different providers should be defined, coordinated, complementary, and responsive

to the changing needs of patients, their families, and other caregivers, as well as to resource availability.

- The patient must be an active participant in this process, understanding that both the family physician and psychiatrist will remain involved in his or her care and knowing who to contact when a particular problem arises.
- Models of shared care should be sensitive to the context in which such care takes place. Some of the contextual variables that need to be taken into consideration include the socioeconomic setting and demographics of the patient population; the mental health care skills, interest, and comfort level of the family physician; the consultation skills, interest, and comfort level of the psychiatrist; the level of support available from local mental health services and their readiness to take patients identified as needing additional or more intensive psychiatric care; the availability of specialist psychiatric backup; and the availability of local nonmedical mental health resources.

4.2 Strategies for Implementing Shared Mental Health Care

The successful implementation of shared mental health care can bring benefits to family physicians, psychiatrists, patients, and the health care system as a whole (50,51). Three different but complementary strategies can be employed to support and enhance shared mental health care. The choice of strategy will vary according to local needs, resource availability, and other organizational factors. Many of the ideas outlined below have already been successfully implemented, albeit in a limited manner, by practitioners, services, and academic departments in different parts of the country. The goals of these strategies are 1) to improve communication in the working relationship between a psychiatrist or psychiatric service and local family physicians, 2) to establish liaison relationships between psychiatrists or psychiatric services and one or more local family physicians, 3) to bring psychiatrists and/or other mental health providers into the family physician's office.

Strategy 1: Ways to Improve Communication

For the most part, these approaches require minimal time commitment or additional resources and are applicable in almost every clinical setting or community. Improved communication is central to effective shared care.

1. For every person referred to a psychiatrist or psychiatric service, the respective roles and responsibilities of the family physician and the psychiatrist or mental health provider should be made explicit, including the prescription of medication. The patient should be informed of these roles and responsibilities.
2. Family physicians and psychiatrists can get to know each other by arranging shared clinical or educational rounds or one-to-one meetings to discuss difficult cases.
3. Psychiatrists and psychiatric services can improve information transfer by contacting the family physician whenever a patient is referred to a mental health service, significant treatment changes take place, or a patient is about to be discharged to the care of the family physician.
4. Psychiatrists and family physicians can work together to determine what information a psychiatrist or the psychiatric service requires at the time of referral and data a family physician requires in a discharge or consultation note.
5. Family physicians should be contacted and involved at an early stage in developing discharge plans.
6. Psychiatrists and psychiatric services can prepare brief (one-page) summaries of treatment and discharge plans to be given to the family physician at the time of discharge.
7. Similarly, succinct information sheets for family physicians on the management of specific problems or medications can be prepared by psychiatrists to accompany discharge notes.
8. Because family physicians continue to provide physical health care after a patient has been referred to a psychiatrist or psychiatric service, psychiatrists need to ensure that the family physician is informed promptly of any pharmacological intervention. Similarly, family physicians need to inform the psychiatrist or psychiatric service of any drug treatment that may affect the patient's emotional health or interact with a psychotropic medication. This exchange can be facilitated by treatment cards carried by the patient to all appointments, which detail any changes in medication or treatments.
9. Family physicians and psychiatrists should provide each other with the number of their private (back) telephone line and fax number to make communication easier.
10. Family physicians should be accessible to calls from nonphysicians who are working in a psychiatric service and treating or managing their patients. Nonphysician providers should, however, respect the desire of the family physician to discuss pharmacological issues directly with a psychiatrist.
11. Psychiatric services and psychiatrists can provide family physicians with up-to-date information on mental health services available within their community.
12. Psychiatric services should solicit input from family physicians when planning or evaluating mental health services. This can include ongoing surveys of unmet service needs as perceived by family physicians.
13. Psychiatric services and family practices should make any administrative adjustments necessary to facilitate and support better communication.

*Strategy 2: Establish Family Medicine–Psychiatry
Liaison Linkages*

The following approaches involve personal contacts between psychiatrists and family physicians to develop linkages or activities that enhance communication and collaboration and provide mutual support. These can also have an important educational component.

1. Formal links between a psychiatrist and one or more family physicians to provide advice and backup by phone for patients the family physician is seeing. These links can be established with family physicians in general practice and also with physicians who are caring for a large number of patients who share a common predicament such as AIDS patients, members of cultural minorities, or residents of local shelters.
2. Regular meetings to discuss cases. These provide a forum for family physicians to meet with a psychiatrist singly or in groups to discuss complex or challenging cases and receive feedback, advice, and support. These meetings can also enable the psychiatrist to distribute and review relevant educational materials.
3. The development of a model similar to the obstetric shared care model employed in some parts of the country. This would identify levels of risk or complexity for each patient with guidelines as to the roles and responsibilities of the psychiatrist or psychiatric service and the family physician.
4. The development of rapid reassessment protocols for patients who have been seen previously by a psychiatrist or psychiatric service. If a family physician is providing ongoing care for a patient discharged from a psychiatric service, that psychiatrist or service should offer a rapid reassessment when this is requested by the family physician.
5. The provision by psychiatrists or psychiatric services of educational materials such as screening instruments, useful articles, or treatment protocols to local family physicians that may assist in the management of their patients. This can be followed up by a telephone call to answer any questions the family physician may have concerning the use of the materials.
6. The availability of psychiatrists to provide support, advice, or a consultation to family physicians who manage their own patients during an inpatient admission to hospital.
7. The organization of periodic joint hospital rounds for psychiatrists and family physicians on topics of mutual interest.
8. The development by family physicians of registers of patients in their practice who are at risk of developing specific psychiatric problems, for example, individuals who have a psychotic illness or who are elderly and isolated. These lists can be reviewed by the family

physician in conjunction with a psychiatrist on a regular basis to ensure that these individuals are seen routinely and that their treatment needs are addressed.

*Strategy 3: Encourage Visits by Psychiatrists to
Family Physicians' Offices*

In some situations, there may be opportunities for a psychiatrist to spend part of his or her week working within a family physician's office. An essential component of this strategy is the ongoing contact between psychiatrist and family physician. There are a number of ways to achieve such contact:

1. The psychiatrist visits the family physician's office on one or more occasions to provide follow-up for a recently discharged patient. This may involve a review of plans and progress or a meeting together with the patient. It may occur at a prearranged time after discharge or if a new problem arises.
2. The psychiatrist visits a family physician's office periodically to provide consultations or review specific problems on an as-needed basis.
3. The psychiatrist visits the family physician's office on a regular basis. Visits may be as brief as an hour or as long as a full day. Such visits could involve the assessment of new patients, follow-up of patients previously seen, a review of patients or problems the family physician is managing, and focused educational sessions on topics of the family physician's choosing. The psychiatrist and family physician work collaboratively, sometimes seeing patients together, and discuss their respective responsibilities for the patients for whom they are caring.
4. The psychiatrist functions as a member of a mental health team located in the family physician's office. While the activities of the team may be similar to those described above for the visiting psychiatrist, the psychiatrist can play a number of additional roles:
 - i. The psychiatrist provides backup or consultation to the family physician, mental health workers (for example, social workers, nurses), and any other health workers (for example, a community nurse) attached to that practice. This can be done by phone or by regular visits to the family physician's office.
 - ii. The psychiatrist visits the family physician's office on a regular basis to work collaboratively with the family physician and mental health worker(s) seeing patients as well as to be available for consultation and backup.
5. The psychiatrist provides educational interventions within the family physician's office. Working in the family physician's office opens new avenues for innovative approaches to continuing education with family physicians. This can be done by one-to-one sessions with a single family physician or educational sessions

with a group of family physicians working in that practice on topics of the family physician's choosing.

4.3 Additional Steps Required to Support These Strategies

To support the specific strategies outlined above, the following steps need to be taken.

1. Psychiatric services need to make entry into the "formal" mental health system as efficient as possible. This means dismantling unnecessary administrative obstacles and giving a clear message that a referral is welcome and assistance will be forthcoming.
 2. Family physicians need to be willing to provide ongoing care for many individuals with mental illness, knowing that appropriate support and input from mental health services will be available if requested.
 3. Two-way communication between care providers must take place on a regular basis.
 4. Partners in shared care should establish personal contact with each other and be able to provide each other with mutual support and information on the management of patients with mental health problems.
 5. The location where care is delivered can vary according to the needs of the patient.
 6. There needs to be ongoing evaluation of the impact and outcomes of shared mental health care, with activities being adjusted according to findings.
 7. The family physician(s) and psychiatrist need to meet before any collaborative activity is initiated to clarify their common agenda, goals, and expectations and to determine how the success of any such approach will be measured. Ongoing review meetings need to take place periodically.
 8. The psychiatrist and family physician must clarify respective roles and responsibilities in every situation where care is being shared.
1. A visiting psychiatric consultant who periodically spends a defined amount of time in the community (for example, a day every 4 to 8 weeks), providing consultation and follow-up as needed. When visiting a community, the psychiatrist needs to work closely and collaboratively with the family physician to ensure continuity of care. Time can also be spent reviewing cases and discussing problems with cases the family physician is handling and in educational sessions for local providers. The psychiatrist will also be available for telephone consultation in between visits.

This can also be combined with case review groups, in which family physicians meet as a group with the visiting psychiatrist to discuss and monitor the progress of selected cases, some of whom the psychiatrist may be familiar with from a previous visit. These groups could also meet in between visits as a peer-support group.
 2. The availability of a psychiatrist working in a more populated centre to provide consultations or advice by phone to family physicians in more isolated communities.
 3. Utilization of newer technologies, such as video conferencing, to provide clinical consultation and educational input.
 4. Educational sessions and workshops organized by a visiting psychiatrist on practical management issues, with opportunities for follow-up after the session (telephone discussions).
 5. Ongoing educational forums involving psychiatrists and family physicians organized through the Internet.
 6. Further training in residency programs for family physicians from isolated communities to enable them to develop additional skills in managing mental health problems.
 7. The development of self-administered computerized educational packages.

OTHER IMPLICATIONS OF SHARED MENTAL HEALTH CARE

5.1 Implications for Underserved Communities

In many of Canada's more isolated communities, where a psychiatrist is not available on a permanent basis, the family physician usually assumes a more prominent role in delivering mental health care. Shared care offers a number of possibilities for reinforcing and supporting the role of the family physician and using scarce resources as efficiently as possible. Most provinces have already implemented some of these ideas, but the key to their successful implementation is adherence to the principles outlined earlier. In underserved communities shared care may involve the following elements.

5.2 Implications for Academic Departments of Psychiatry and Family Medicine

Departments of psychiatry and family medicine should see primary care psychiatry or shared mental health care as a core area of clinical activity, emphasizing and supporting its importance in educational programs.

Training

Many of the problems in the relationship between psychiatrists and family physicians reflect the fact that little attention is paid to collaborative models of practice in residency training programs. If significant changes are to be wrought in clinical practice, they need to begin with appropriate educational experiences that prepare trainees for the realities of collaborative care.

For psychiatry residents, training programs should provide 1) contacts with family physicians and family medicine residents in a variety of settings throughout their training. These can be a part of rotations such as outpatient, child, or geriatric psychiatry; 2) an understanding of the role the family physician plays in managing mental health problems and the kinds of problems the family physician manages; 3) practical skills in primary care consultation; 4) exposure to role models who are experienced in primary care consultation and shared mental health care; and 5) practical experiences and supervision in working within models of shared mental health care.

The ability to offer satisfactory training experiences in primary care psychiatry may become an accreditation requirement of residency programs. National standards should be developed for satisfactory training in these areas within psychiatry residency programs by the RCPSC, in conjunction with the CPA and CFPC. Such training would be consistent with the recently established CanMEDS 2000 program established by the RCPSC, which aims to prepare residents to meet the future health care needs of Canadians (52). Roles identified for specialists that should be highlighted in residency training programs include those of medical expert, communicator and collaborator.

For family medicine residents, training programs should provide 1) contacts with psychiatrists and psychiatry residents in a variety of settings throughout their training; 2) training on how to make optimal use of a psychiatric consultation or a psychiatrist who visits their office; 3) an understanding of the principles of shared mental health care and ways in which psychiatrists can assist family physicians; 4) exposure to role models who can work collaboratively with psychiatrists; and 5) practical experiences and supervision in working within models of shared mental health care.

In undergraduate medical programs, the principles of shared care between family physicians and all medical and surgical specialties, as well as ways in which such approaches can be implemented, should become a part of the undergraduate curriculum, forming an integral part of any teaching that addresses the physician's roles and responsibilities, continuity of care, and the most efficient use of resources.

Finally, for postresidency training, departments could establish fellowships to provide additional training in this area.

All of these training programs could be enhanced if departments can recruit faculty with expertise in shared mental health care who could play active roles as supervisors and role models and provide leadership in the development of academic programs in aspects of shared care.

Research

Academic departments could play central roles in initiating and supporting research projects and grant proposals

seeking to evaluate models of shared mental health care and their impact on local health systems.

Interdepartment Collaboration

Departments of psychiatry and family medicine should establish closer ties. These could enhance and support clinical activities, enrich teaching programs, and generate collaborative research projects. One further area of potential collaboration would be for academic departments to find ways of initiating and supporting outreach activities by psychiatrists to underserved communities.

5.3 Implications for Continuing Education

One of the important benefits of shared care is the opportunity for participants to increase their skills and knowledge. Collaboration between psychiatrists and family physicians offers many exciting educational possibilities. These include:

1. Brief, focused, case-based educational presentations and discussions. This includes regular meetings of groups of family physicians with a psychiatrist to review cases.
2. Brief one-to-one or small-group educational activities within the family physician's office, if a psychiatrist is visiting on a regular basis.
3. Opportunities for psychiatrists to update their knowledge of general medical conditions and their treatment. This is consistent with the need for psychiatrists to reinforce their medical skills to be able to work optimally as consultants to other physicians.
4. The use of new educational technologies (computer educational programs, Internet linkages) reinforced by regular contact between family physicians and psychiatrists.
5. The application of evaluative data on models of collaborative care within practices and clinics.
6. Continuing education credits for nontraditional educational activities within the family physician's office.

5.4 Possible Barriers to Implementation

Despite the many benefits of shared mental health care, there are a number of possible obstacles that need to be overcome. These include:

- the current fragmentation of planning between primary care and mental health services at both provincial and local levels in most Canadian provinces
- lack of recognition of the role of the physician in mental health reform and health care planning
- increasing patient loads faced by many family physicians and psychiatrists

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- insufficient numbers of psychiatrists in certain parts of the country
- a lack of necessary skills in consultation to primary care physicians by some psychiatrists
- insufficient emphasis on primary care consultation in psychiatry residencies issues of confidentiality that may limit physician-to-physician communication
- a lack of clarity concerning the assignation of medico-legal responsibility in shared mental health care
- negative attitudes on the part of some family physicians and psychiatrists toward the contributions the other can make
- problems with current systems of remuneration, which do not cover indirect (nonpatient contact) services such as case discussions, educational input, or travel to and from a family physician's office.

There appears to be a consensus among psychiatrists and family physicians across the country that this last point may be the most significant barrier to the successful implementation of shared care and that alternate methods of remuneration will be required to support these activities.

SYSTEM-WIDE CHANGES REQUIRED TO SUPPORT SHARED CARE

Changes at the provider level need to be reinforced by adjustments within regional and provincial mental health systems and in family medicine and psychiatry professional associations. We would recommend the following:

1. Family physicians and psychiatrists look at ways of establishing closer ties, consistent with the guidelines of this document.
2. Within communities, networks of family physicians and psychiatrists who are interested in collaborative care be established. Participants would be able to exchange ideas, share experiences, and advocate for the development of pilot projects.
3. Funding and resources be made available for demonstration projects of shared mental health care, which will be evaluated.
4. Evaluation protocols be developed to assess the impact of shared care on patient outcomes, service utilization, costs of health and mental health care delivery, and community well-being. These could be developed by one or more centres and made available on a province or nationwide basis.
5. A national clearinghouse be established to compile descriptions of programs and useful materials (such as discharge forms or educational packages) that would be available to all interested practitioners across Canada.
6. New funding approaches be developed to support the implementation of some of these strategies. Options

could include the provision of alternate methods of remuneration for psychiatrists, such as sessional fees; changes in provincial fee schedules to cover services rendered by psychiatrists and family physicians that do not involve direct (the patient is seen) patient care; alternate funding arrangements for primary care, such as global budgets or capitation, which could fund services provided by psychiatrists; the secondment of mental health staff from clinics to family physician's offices; or incentives to encourage family physicians to spend necessary amounts of time with individuals with complex psychiatric disorders.

7. Regional planning authorities consider the potential role that shared mental health care could play in building continuous service networks.
8. Provincial planners continue to explore the possibilities of shared care approaches as part of the solution to the shortage of psychiatrists in isolated areas.
9. Academic departments of psychiatry and family medicine review their curricula to ensure that residents receive appropriate preparation to enable them to work collaboratively after graduation.
10. Academic departments of psychiatry and family medicine consider the possibility of emphasizing linkages between family physicians and psychiatrists as a focus of academic excellence, offering specialized training for residents and fellows and supporting collaborative investigative projects.
11. The CPA and CFPC establish an ad hoc conjoint working group to oversee the implementation of the recommendations of this report and to address other related issues.
12. The CPA and CFPC encourage provincial colleges of family physicians and psychiatric associations to establish joint provincial working groups to facilitate better coordination of planning, research, and educational initiatives at provincial levels.
13. Provincial governments look at ways to begin to integrate planning processes for mental health and primary care reform.

Conclusion

In a period of rapid change in the organization of health service across Canada, the concepts that underlie shared mental health care between psychiatrists and family physicians are straightforward and timely. If family physicians and psychiatrists can work together, they can enhance continuity of care, strengthen the continuing relationship a family physician has with his or her patient, and increase the accessibility of psychiatric care.

Shared care is not an alternate style of practice, but rather a component of health care that can be easily integrated with other treatments employed by psychiatrists

and family physicians. Many of the ideas outlined in this document, especially those that aim to improve communication, are simple to implement but could bring rich dividends to all concerned. Other strategies are more complex and will require changes in the ways in which physicians are funded if they are to succeed.

Shared mental health care has the potential to create a better-integrated health care system, one in which providers feel more supported and patients have the easiest possible access to the services they need when they need them. Above all, it is likely to lead to a more efficient health care system and better patient outcomes. It is a concept whose time has arrived.

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Printing of this document was supported by an unrestricted educational grant from SmithKline Beecham Pharma.

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