Easier Access, Less Stigma

Medical Home *from page 1*

medications, Dr. Skully noted that family physicians may not be comfortable using atypical antipsychotics and higher doses of antidepressants. Residents also are learning how to effectively target antidepressants in patients with different presenting symptoms. In addition to learning to select and dose psychotropic medications, residents also learn how to probe into other possible diagnoses.

From the patient's perspective, embedding this type of care within the medical home provides a great deal of comfort, Ms. Martin said. There's much less stigma involved in saying "I'm going to my family doctor's office," she noted.

The vulnerability of these patients is made all the worse by the fact that they are often the population that is most weary—and the most wary—of treatment, so that in many cases, the in-house presence of a psychiatrist provides a lot more than just convenience. For many patients, especially those who are on Medicare or who are uninsured, it's the difference between getting the care they need and not getting it, Dr. Skully said.

Outside of their program, patients in lower socioeconomic brackets routinely get referred to an overburdened countywide service that provides initial crisis intervention and referrals. Under that system, unless a patient is suicidal or psychotic enough to warrant inpatient care, patients usually wait up to 6 months before they have a psychiatric consultation. By then, the urgency often has passed and the patient doesn't bother keeping the appointment, Dr. Skully noted.

Before Grant Family Medicine brought a psychiatrist in house, "except in the cases of emergencies, I don't know if I ever had a patient make it through the system and actually see a psychiatrist," Dr. Skully said.

"Even for our economically disadvantaged patients, our show rate is about 60%-65%." So when patients need a mental health consultation, they get one within a week to 10 days in about two-thirds of the cases. That just doesn't happen otherwise, he said.

The effectiveness with which managed care ratcheted down mental health care spending has resulted in a significant lack of access to mental health professionals. Young people don't want to go into psychiatry as they used to, said Ms. Martin, a licensed professional clinical counselor.

Outside major metropolitan cities, the wait for a psychiatric consultation can be several months. And even in large cities, such as Denver, poor access to mental health providers means that family physicians are managing mental diagnoses that are beyond their comfort level. (See 'reluctant' psychiatrists story below.)

Dr. Kovell's expenses initially were covered by the United Way grant. Currently, he is paid as a part-time faculty member. Dr. Skully and Ms. Martin admit that Grant Family Medicine's income stream as an academic medical center shelters the institution from the financial aspects of including a psychiatrist on its payroll, but they suggested that private practices may want to explore similar options. Providing office space to a psychiatrist in the area, even just one day every few weeks, may be a good place to start, Dr. Skully said. ■

Self-Management Tool Helps Patients Navigate Depression

BY KATE JOHNSON
Montreal Bureau

Family physician Patrice Ranger estimates that she sees about 10 depressed patients a week at the student health services clinic at the Simon Fraser University campus in Burnaby, B.C. That's about 10% of her practice.

However, she can help a fair number of those patients by encouraging self-management techniques that involve just one or two office visits and often no medication. "Whether it's mild, moderate, or severe depression, there's always room for this type of tool—perhaps as a sole treatment in a mild depression, or as an adjunctive tool in more moderate or severe depression," she said in an interview.

Supported self-management draws on the principles of cognitive-behavioral therapy (CBT) and is based on the premise that patients can actively participate in their own depression treatment by using techniques to change attitude and behavior. The approach is guided by a workbook or an online interactive program that teaches skills for combating the negative thought patterns that contribute to depression.

Self-management is overseen by a coach or supporter who is often a health care provider, but also can be a family member or friend, said Dan Bilsker, Ph.D., a psychologist at the university who developed the workbook Dr. Ranger uses.

Self-management of depression—also known as guided self-management—is becoming a standard component of the mental health care system in the United Kingdom and Australia, Dr. Bilsker said. "It's as low cost as any intervention gets; it's low risk, user friendly, and evidence based."

Yet not much is known about it, nor is it widely used in the United States, even though it fits "with the emerging paradigm of collaborative health care and serves to maximize the impact of an existing health care system by extending the reach of primary care," he said in an interview.

And it is ideal for a primary care setting. "Primary care is carrying the burden of most intervention for depression. [Most] people with depression see only a primary care physician and have no contact at any point with the psychiatric system."

Given the time constraints and patient load of most primary care physicians, medication is often the treatment of choice for depression, although there is little evidence to support its benefit in minor depression, Dr. Bilsker said. Supported self-management, on the other hand, is an initial treatment that is as time efficient as medication, with a more favorable risk profile. "It gives an alternative [and] leaves open the option of the physician adding medication later."

Dr. Ranger said she advises the approach to most of her patients as a first step. "You don't just give it to them and send them away. [They] come back within 2 weeks to discuss how they're feeling."

Even if she decides that medication is needed, she retains the self-management techniques as an important part of the treatment. "This is one way of learning skills that can help over your lifetime. The medicine may be needed for the here and now or for a longer time, but that's only part of the treatment. The other part is looking at a person's skills and thought processes. People can learn that they have some control with very practical things such as goal setting and self-care."

Dr. Bilsker noted that the supported self-management approach is also attractive to patients. "Studies show that many people want to be actively involved. They don't always want to hand it over to a professional. This is part of an overall shift in the management of all chronic diseases …to give the patient[s] tools, training, and support so they are a part of their recovery process."

The workbook can be downloaded, for free, by going to www.carmha.ca/publications/resources/asw/SCDPAntidepressantSkills.pdf). Dr. Bilsker has written versions of the original workbook that focus on adolescent depression and workplace depression. ■

Mental Health Care Gaps Recast PCPs as 'Reluctant' Psychiatrists

BY BETSY BATES
Los Angeles Bureau

VANCOUVER, B.C. — Primary care physicians in community health centers say they are practicing "reluctant psychiatry" because mentally ill patients with chronic diseases often have nowhere else to turn for care, Dr. Carol Darr reported in a poster presentation at the annual meeting of the North American Primary Care Research Group.

"They hate it. They're dealing with many, many things beyond the scope of their knowledge," said Dr. Darr of the Colorado health outcomes program at the University of Colorado Health Science Center in Denver.

Dr. Darr and her associates conducted 71 semistructured interviews with primary care physicians and staff members and observed 198 hours of clinical care and practice processes at seven community health care centers that serve uninsured or underinsured working poor families in the Denver region.

They found that mental health issues significantly complicated the care of chronically ill patients served by the clinics, but that a combination of spending cuts and a shortage of mental health professionals created barriers in referral.

The physicians said they felt they were often "on their own," either consciously ignoring clues to mental health issues or practicing "reluctant psychiatry" outside of their scope of expertise, said Dr. Darr in an interview at the meeting.

Statements by the respondents illustrated their high level of frustration as their clinics are increasingly forced to manage chronically ill patients with mental health problems. In many cases, specialty clinics have closed or cut back their services because of funding cuts. Other times, families lose access to care through the loss of Medicaid or other insurance programs.

"This is beyond me," one physician said of a particular patient. "I don't know what to do with the man. I've adjusted his meds as much as I can do [as] a primary care person. But he needs a little bit more than that—he's still hearing voices."

Another physician described a patient who saw a psychiatrist and received psychotropic medications while hospitalized but did not receive them after her release.

"She's 100% in-house managed now," the physician said. "And this woman truly does need to see a psychiatrist …somebody who understands psychosis and … all the antipsychotics and all the medications that she's on. As family practitioners, we do the best we can, but we're not psychiatrists. She's pretty poorly controlled."

Yet another physician said, "If you feel you don't have a lot of tools at hand to deal with the mental health side of things, that tends to be the last thing you get to … why open that can of worms if you don't know [how] to solve the problem?"

Respondents described trying to obtain more psychiatric training "on their own or on the job" and said they sometimes have to "curb side" a psychiatrist to obtain an informal consultation about some of these cases, said Dr. Darr.

One physician recalled getting a telephone consultation with a psychiatrist who vowed never to speak to him again after he learned that his name would appear in the patient's chart.

Dr. Darr said the findings suggest that those compiling medical education models and drawing up clinical guidelines may need to rethink their assumptions that primary care physicians have the option of referring patients with serious mental health disorders to psychiatrists. Risks and liability issues are elevated whether primary care physicians ignore mental health issues or treat complex disorders outside of their scope of practice, she added.

"Reluctant psychiatry exacts a toll on the individuals forced to practice it, on the patients whose care is compromised for lack of appropriate specialty care, and on the society that absorbs the cost of supporting increasing numbers of individuals whose physical and mental health are poorly controlled," she concluded. ■