Linkages between Primary Care Providers and Mental Health Specialists

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Primary care physicians are integral to the provision of mental health services. The primary care physician (PCP) is often the first, and sometimes the only physician who treats patients with mental health (MH) problems.[1] In this era of managed care, the PCP's role includes responsibility as a utilization "gatekeeper" in addition to diagnosing, treating and referring patients to specialists when necessary.[2] While many studies have assessed to what degree PCPs are prepared to diagnose and treat patients with MH problems,[3-5] fewer studies have described the linkage relationships that PCPs have with MH specialists even though these relationships may be crucial in supporting PCP's management of patients with mental disorders. (Please refer to the article in this issue of the Newsletter by Dembow, "The Jefferson Behavioral Health Network: A Multi-System Approach to Mental Health Management.") Different models of PCP/MH linkage have considered combinations of organizational, structural, and interpersonal factors.

Organizational and locational factors may shape linkages to include: 1) MH care provided within comprehensive medical clinics; 2) consultation and/or referral by PCPs to other outpatient MH settings; 3) stand-alone MH clinics where treatment, but not consultation with PCPs was common; and 4) stand-alone MH consultation clinics.[6] Another model of PCP/MH linkages considers interaction(s) between providers: 1) Who are the providers? (i.e., family physician, psychiatrist, social worker); 2) What is the relationship between the providers? (i.e., is it joint care, consultation, referral, or independent care?); and 3) When during patient care does communication takes place? (i.e., is it during patient diagnosis/assessment, short term management, or long term management?).[7] Other models consider individual provider characteristics such as demographics (age, years in practice, job stress, physician work load); physician beliefs and practice style (especially beliefs about stigma, cause of symptoms, sensitivity to MH issues, style of interviewing); as well as physician practice structure (such as the size and resources of practice; comfort with collaboration; specialty, cultural, community interests).[8]

Despite many models of collaboration, little is known about the actual nature of PCP/MH linkage relationships. In an exploratory study, PCPs affiliated with Jefferson Medical College in Philadelphia, Pennsylvania were surveyed on the nature and quality of consultation and referral practices they had with individual mental health providers and mental health carve-out organizations.

Ninety-nine attending physicians from the Department of Family Medicine and the Division of Internal Medicine responded to the survey. Physicians' perceived ability to treat mental illness was positively related to the availability of MH consultation, with 51.4% of the physicians with any availability reporting excellent/very good ability to treat MH, compared to 29.7% of the physicians with no availability (chi-square=7.08, p=.029). Many physicians reported neither providing nor receiving information back from MH providers48.5% of physicians often or always provided patient information to individual mental health providers, but only 25.0% often or always received patient information in return (Bowker's test for symmetry=21.19, p=.001). Physicians expressed high levels of dissatisfaction with mental health carve out programsonly 33.3% were satisfied with their relationships to mental health

carve out programs, compared to 65.2% for individual mental health providers (Bowker's test for symmetry=21.59, p=.001).

As PCPs' perceived ability to treat MH patients was positively related to the availability of MH consultation, ongoing relationships with MH professionals may assist PCPs in developing their ability to manage these patients. PCPs' increased comfort levels in treating mental illness when they had access to MH consultation points to the utility of having MH providers provide regular inservices and consultative support to PCPs. In addition, PCPs felt that the quality of collaboration and referral relationships for mental health problems with individual providers was markedly better than those relationships with managed care carve-out programs. This may point to administrative constraints that many PCPs feel hamper timely access to patient care as well as patient care continuity.

For many patients, physicians must act as advocates who articulate concerns regarding quality of care. The PCP is envisioned in managed care environments as that advocate, who has an overall picture of the patient's health. In order to perform this role well, relationships with other clinicians such as MH specialists must be fashioned and maintained. Ultimately, the nature and quality of collaboration and referral relationships between PCPs and MH providers may affect patient outcomes such as recovery and non-remission, service use and costs, and patient satisfaction.

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