Collaboration Between Mental Health Professionals and Family Physicians: A Survey of New Jersey Family Physicians

Chantal M. L. R. Brazeau, M.D.; Sue Rovi, Ph.D.; Christina Yick, M.D.; and Mark S. Johnson, M.D., M.P.H.

Received Sept. 7, 2004; accepted Nov. 8, 2004. From the Departments of Psychiatry (Dr. Brazeau) and Family Medicine (Drs. Brazeau, Rovi, and Johnson), New Jersey Medical School, Newark; and the Department of Pediatrics, New York University Medical School, New York (Dr. Yick).

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Corresponding author and reprints: Chantal M. L. R. Brazeau, M.D., New Jersey Medical School, MSB Room B 646, 185 South Orange Ave., Newark, NJ 07103 (e-mail: brazeacm@umdnj.edu).

Background: Mental health problems are frequent in primary care, and there are many barriers to their detection and treatment. Clinical research protocols that include close collaboration between mental health professionals and primary care physicians have been found to be beneficial. This study explores the opinions of community family physicians regarding mental health professionals working directly in the primary care office.

Method: Members of the New Jersey Academy of Family Physicians (N = 709) were sent a 25-item questionnaire about collaboration with mental health professionals. Three mailings were sent, with a 62% response rate. The surveys were mailed between May and July 1999.

Results: Of family physicians included in the analysis, 13.5% reported having an in-office mental health professional. Of those who did not, 60.2% responded that they would consider having one. Compared with physicians who would not consider having an in-office mental health professional, physicians with a mental health professional and those without an in-office mental health professional but who would consider one were statistically more likely ($p < .01$) to respond that an in-office mental health professional would result in increased use of mental health services, improved acceptance of referrals to mental health professionals, and improved detection and treatment of mental health problems.

Conclusion: Although few family physicians have an in-office mental health professional, many more would consider this arrangement and recognize the potential benefits of such collaboration.

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Up to 26% of primary care patients have a diagnosable mental health problem.[1,2] Many others have less severe problems that may negatively impact their functioning.[1] About two thirds of patients with mental health problems are not detected by their primary care physician,[3–6] and many of those who are detected and referred to a mental health professional (MHP) refuse the referral.[7,8]

Barriers to the detection and treatment of mental disorders in primary care include time constraints and competing demands from other medical problems.[9] The stigma associated with mental disorders can also affect patient presentation and physician detection.[7,8] The current health care system, with mental health often being reimbursed less fully than and separately from physical problems ("carved-out"), can pose problems with availability of mental health care for patients and with communication between the referring physician and MHPs.[10,11] In a systematic review of interventions to improve the management of depression in primary care, the passive dissemination of guidelines to improve the recognition and management of depression was found to have minimal effect on the care of depression in primary care.[12] Because of this, models of health care that include collaboration between MHPs and primary care physicians have been

advocated.[10] For example, Katon et al.[11] have studied a model in which family physicians treated depressed patients with planned interventions by a psychiatrist at specified intervals and monitoring of patients' adherence to medication. They found that patients treated collaboratively had improved compliance with medication and patients with major depression had more favorable treatment outcomes. In another study, patients with persistent depressive symptoms after initial treatment for depression had better outcome with treatment using collaborative care than care with the primary care physician alone.[13] Other research has shown collaboration between MHPs and primary care physicians to be beneficial[12–16] and cost-effective.[17–20]

To explore the potential of collaboration between family physicians and MHPs in community settings, New Jersey family physicians were surveyed. Specifically, questions were asked to find out if family physicians were collaborating with MHPs who work within the family physician's office and, if not, whether physicians would be interested in such in-office collaboration. To our knowledge, there are no studies that report how many family physicians work with an MHP in their office. Our hypotheses were that (1) most family physicians in the community would not have an in-office MHP and (2) if financially feasible, most family physicians would be interested in having an MHP work in their office to assist them with detection and treatment of mental health problems.

METHOD

A 25-item questionnaire was developed and pilot tested by the faculty of the Department of Family Medicine (New Jersey Medical School, Newark). The survey is available from the authors on request.

We surveyed all 709 family physicians who were active members of the New Jersey Academy of Family Physicians in 1999. Three mailings were conducted between May and July 1999. Physicians who had stopped practicing medicine for more than 1 year or who had retired were excluded. Because family medicine residency programs must have behaviorists in the office (often an MHP with variable patient involvement) due to teaching requirements, family physicians based in residency programs were excluded from the data analysis.

The questionnaires were coded and analyzed using SPSS (Statistical Package for the Social Sciences; SPSS Inc., Chicago, Ill.). We used frequencies and χ^2 testing to do a 3-way comparison and subgroup analyses of physicians with an in-office MHP, physicians without an MHP but who would consider having one, and physicians without an MHP who would not consider having one, to compare data on demographic variables and beliefs about MHPs.

RESULTS

Of 709 surveys distributed, 439 were returned by actively practicing physicians (response rate = 62%). Seventy-three surveys were excluded because the physician was based in a residency program. This left 366 surveys for analysis (52% of distributed surveys). There were no statistically significant differences in age or sex of respondents compared with nonrespondents. Most family physicians (86.5%) reported that they did not have an in-office MHP. Of those, 60.2% said they would consider having one.

In a 3-way comparison, physicians with an MHP and those without an MHP but who would consider having one were statistically more likely ($p < .01$) than physicians without an MHP and who would not consider one to be female, be younger, have completed a family medicine residency program, and have fewer years practicing medicine since residency (Table 1). They were also more likely ($p < .01$) to respond that an in-office MHP would result in increased use of mental health services, improved acceptance of referrals to MHPs, and improved detection and treatment of mental health problems. In subgroup analysis, there were no statistically significant differences in terms of demographics or opinions about MHPs between physicians who had an in-office MHP and those who did not have an MHP but who would consider having one. Of family physicians who already had an in-office MHP, 26.5% worked with a social worker, 22.4% with a psychologist, 10.2% with a psychiatrist, 4.1% with other MHPs, and 36.5% with more than 1 MHP in various combinations of the above.

DISCUSSION

A significant number of community (non-residency) family physicians (13.5%) have already established an in-office collaboration with an MHP, and many of the rest would consider such collaboration, particularly physicians who are female, younger, and residency-trained in family practice. Compared with male physicians, female physicians have been reported to engage in significantly more psychosocial counseling and question-asking in patient encounters,[21] which may fuel their interest in collaborating with MHPs. Younger and residency-trained physicians may be more comfortable working closely with MHPs since they may have experienced such outpatient collaboration during their family medicine residency training. Physicians who already had an in-office collaboration seemed to prefer social workers and psychologists, which may also be related to their exposure to those specialties during residency training.

The study is limited by the fact the sample included only New Jersey family physicians and did not explore how the MHPs are reimbursed. Obtaining such informa-

Table 1. Comparisons Among New Jersey Family Physicians With and Without an In-Office Mental Health Professional (MHP) and, of Those Without an MHP, Those Who Would and Would Not Consider Such a Collaboration[a]

Variable	Total (N = 358)[b]	With MHP (N = 48)	Without MHP, but Would Consider One (N = 185)	Without MHP, and Would Not Consider One (N = 125)
Sex, male, %	69.6	60.4	65.4	79.2
Age, mean (SD), y	44.5 (9.8)	42.7 (8.8)	42.8 (8.8)	47.9 (10.8)
Completed family medicine residency program, %	86.2	89.6	90.7	78.2
Years in practice, mean (SD)	12.8 (9.6)	10.8 (9.1)	11.3 (8.5)	15.8 (10.7)
Opinions, % of respondents[c]				
More likely to utilize services of an MHP if based in-office compared with an out-of-office referral	47.9	68.7	57.5	25.8
Patients more likely to accept a referral to an in-office MHP compared with an out-of-office referral	54.2	70.2	63.8	33.9
In-office MHP advantageous for detection of mental health problems	29.5	50.0	36.6	11.3
In-office MHP advantageous for treatment of mental health problems	49.1	73.0	60.7	22.6

[a]Physicians with an MHP and those without an MHP but who would consider one were statistically different from physicians without an MHP and who would not consider having one on all parameters ($p < .01$). Differences between those with an MHP and those without an MHP who would consider one were not statistically significant.
[b]Total N used for analyses in the table was 358; although the number of surveys returned was 366, some had missing values for items reported in the table.
[c]Respondents were asked to provide their opinions based on a 5-point Likert scale: 1 = "not at all," 2 = "a little bit," 3 = "moderately," 4 = "quite a bit," and 5 = "extremely." Responses were recoded for presentation purposes to reflect combined percentages for 4 or 5.

tion would be the next step in exploring collaborative care as an alternate form of delivery of mental health services in our current health care system. Gaining information about reimbursement of in-office MHPs is especially important since mental health is often carved out of medical, nonpsychiatric health care benefits, which contributes to barriers to treatment of mental health problems.

CONCLUSION

Most family physicians in New Jersey do not have an in-office MHP, but 13% do, and many more would consider this arrangement. Most physicians recognize the benefits of collaboration with an MHP. Further studies are needed to investigate the financial feasibility of having an MHP in a family physician's office.

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