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Strategies of Collaboration between General Practitioners and Psychiatrists: An Exploratory Research Project in Montreal

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ABSTRACT

An exploratory research project was carried out with the overall objective of identifying strategies which may improve collaboration between general practitioners (GPs) and psychiatrists at the primary care level. This research project is described within two contexts: a) the historical quantitative-qualitative research debate, and b) the disease model along with other models of health care delivery. Two consecutive studies were conducted: one qualitative (first), the other quantitative (second).

The qualitative study was conducted in eastern Montreal between 1998 and 1999. The general study objective was to identify the key strategies which may increase collaboration between GPs and psychiatrists in the delivery of mental health services in primary care settings. In order to achieve this objective, information was collected on working patterns involving GPs and psychiatrists, their perceived roles and respective expectations, the barriers to collaboration, and suggestions for improvement of collaborative service delivery. All information was gathered from a purposefully selected sample of five GPs and five psychiatrists. Ten individual in-depth interviews and one focus group session were conducted.

Three groups of strategies were identified: 1) communication, 2) Continuing Medical Education (CME) for GPs in psychiatry, and 3) access to consulting psychiatrists in primary care settings. These groups of strategies set the basis for the quantitative study.

This study consisted of a survey conducted in the fall of 2000 in the metropolitan area of Montreal. The survey had two objectives. The first was to collect the opinions of both GPs and psychiatrists practicing in Montreal with respect to strategies for improving collaboration between them at three levels - communication, CME for GPs in psychiatry, and on-site collaboration in primary care settings. The second was to identify demographic and practice characteristics of physicians associated with the acceptance of such strategies.

A questionnaire was specifically designed to elicit physicians' agreement or disagreement with the strategies of collaboration and was mailed to 203 GPs and 203 psychiatrists randomly selected. The survey response rate was 86% for GPs and 87% for psychiatrists. The physicians expressed favorable opinions about most strategies involving 1) the improvement of communication and 2) the organization of CME activities concerning GPs' practices in the field of psychiatry. However, they did not indicate agreement with the strategies involving on-site collaboration in primary care settings. Physician gender, age, place of practice, type of practice (such as seeing patients with or without appointments), and responsibility for administrative duties were significantly associated with the degree of agreement with the proposed strategies.

The improvement of collaboration between GPs and psychiatrists is linked to specific strategies and physician characteristics. Most physicians may accept strategies involving communication and organization of CME for GPs in psychiatry. However, strategies of on-site collaboration may be only accepted by specific groups of GPs and psychiatrists who might share characteristics associated with propensity for closer collaboration.

KEY WORDS: collaboration; general practitioner; psychiatrist; primary care; qualitative methods; quantative methods.

RÉSUMÉ

Le système de soins de santé au Québec a connu des transformations importantes. Des soins autrefois offerts dans le milieu hospitalier ont été transférés vers les services externes de première ligne. En outre, dans le domaine de la santé mentale, on observe que les omnipraticiens ont une clientèle renfermant beaucoup de patients souffrant de troubles mentaux.

Dans la population générale, seule une faible proportion des individus atteints de troubles mentaux recherchent de l'aide professionnelle. Ceux qui le font s'orientent vers les services externes de première ligne. Les omnipraticiens sont souvent les professionnels auxquels ces individus en détresse s'adressent d'emblée. Généralement, ces professionnels voient la majorité des patients souffrant des troubles mentaux et jouent donc un rôle important dans l'offre des soins en santé mentale. Toutefois, les omnipraticiens ne peuvent à eux seuls dispenser à ces patients tous les soins requis. La collaboration avec différents professionnels est donc fortement conseillée, en particulier avec les psychiatres.

Dans ce contexte, un projet de recherche de nature exploratoire a été réalisé, pour identifier les stratégies susceptibles de promouvoir la collaboration entre omnipraticiens et psychiatres au niveau des soins de première ligne. Ce projet de recherche comporte une combinaison fructueuse d'une étude qualitative et d'une étude quantitative et se complète par une réflexion conceptuelle à l'égard du débat historique entre la recheche

qualitative et quantitative, ainsi que du modèle de la maladie par rapport à d'autres modèles d'offre des soins de santé.

L'étude qualitative fut réalisée, dans le Montréal Est, entre 1998 et 1999. L'objectif général de cette étude était d'identifier des stratégies cibles aptes à accroître la collaboration entre omnipraticiens et psychiatres et ainsi optimiser la qualité des soins en santé mentale dispensés en première ligne. Pour atteindre cet objectif, des informations furent recueillies au sujet des "patterns" de travail impliquant omnipraticiens et psychiatres; au sujet de leurs attentes respectives quant à leur collaboration et leur perception de leurs rôles propres; au sujet des obstacles à la collaboration ainsi que des suggestions visant améliorer des services assumés conjointement. Toutes ces informations furent recueillies auprès d'un échantillon minutieusement sélectionné. L'échantillon était composé de cinq psychiatres et cinq omnipraticiens. Dix entrevues individuelles en profondeur furent réalisées ainsi qu'une session de groupe de discussion. Le traitement des données fut réalisé par une analyse de contenu, laquelle était guidée par un système préétabli de codage. Trois groupes de stratégies de collaboration furent identifiés: a) la communication; b) la formation médicale continue en psychiatrie (FMCP) pour les omnipraticiens; c) l'accès à des psychiatres consultants. Les deux premiers groupes de stratégies ont été perçus comme étant facilement réalisables avec la participation réciproque des omnipraticiens et psychiatres. Par contre, les psychiatres ne croient pas beaucoup à la viabilité du dernier groupe de stratégies, à cause des

restrictions de temps et de rémunération affectant déjà leurs conditions de pratique. Il fut possible de tracer les profils des médecins les plus favorables à un modèle de collaboration. En effet, les jeunes omnipraticiens ayant complété une résidence en médecine familiale, à l'emploi d'un CLSC, non-rémunérés à l'acte et prodiguant aux patients un suivi à long terme semblent être plus enclins à collaborer. Il en est de même pour les psychiatres impliqués dans la formation de résidents en médecine familiale et ceux qui privilégient, lors de l'approche du patient, un discours actif plutôt qu'une écoute passive. La caractéristique principale commune à ces deux profils demeure l'intérêt du médecin (omnipraticien ou psychiatre) à développer des pratiques de collaboration.

Ces stratégies et ces profils ont servi de base à l'étude quantitative. Celle-ci a consisté en une enquête tenue en automne 2000 dans la grande région métropolitaine de Montréal. L'enquête comportait deux objectifs. Le premier visait à recueillir les opinions des omnipraticiens et des psychiatres pratiquant à Montréal relativement aux stratégies destinées à améliorer la collaboration entre ces médecins à trois niveaux: communication, FMCP destinée aux omnipraticiens et collaboration sur place au sein des services externes de première ligne. Le second objectif visait à identifier les caractéristiques démographiques et les profils de pratique des médecins favorisant l'acceptation de ces stratégies.

Un questionnaire fut donc spécialement conçu pour mesurer, selon une échelle "Likert" à cinq points, le degré d'accord ou de désaccord chez les deux

groupes de médecins au sujet des stratégies de collaboration. Ce questionnaire fut expédié par courrier à 203 omnipraticiens et 203 psychiatres choisis au hasard à partir d'une liste électronique fournie par le *Collège des médecins du Québec*. À la suite de cet envoi postal, trois lettres de rappel furent envoyées aux médecins non-répondants et, en dernier recours pour les non-répondants, un appel téléphonique en a été fait. Les données de l'enquête fut analysées selon les méthodes statistiques bivariées et multivariées. Le taux de réponse au sondage fut de 86% chez les omnipraticiens et de 87% chez les psychiatres.

Les deux groupes de médecins se montrèrent d'accord avec les stratégies de communication. Ces stratégies comportent deux dimensions: a) le contenu des demandes de consultation faites par les omnipraticiens; et b) l'échange d'information entre omnipraticiens et psychiatres lorsqu'un patient est référé au psychiatre.

Les stratégies de FMCP pour les omnipraticiens comportent également deux dimensions: a) l'organisation d'activités de FMCP (ateliers, conférences, mises à jours) conçues pour les omnipraticiens; b) les rapports de consultation des psychiatres considérés comme l'une des ressources de FMCP destinée aux omnipraticiens. Les psychiatres, tout comme les omnipraticiens, ont exprimé leur acceptation du modèle proposé en vue d'organiser la FMC traditionnelle. Ces activités devraient être interactives et axées principalement sur les thèmes couramment observés en pratique par les omnipraticiens. Par contre, en ce qui à trait à l'utilisation des rapports de consultation des

psychiatres comme ressource de FMCP destinée aux omnipraticiens, les avis des deux groupes de médecins diffèrent. Si les omnipraticiens approuvent sans réserve cette stratégie, les psychiatres expriment seulement une tendance à l'accepter.

Les stratégies d'accès à un psychiatre consultant ne renferment qu'une dimension. Cette dernière décrit les tâches du psychiatre consultant susceptibles de faciliter l'accès des omnipraticiens aux services psychiatriques dans les services externes de première ligne. Les deux catégories de médecins, mais particulièrement les psychiatres, n'expriment pas leur accord avec ce dernier groupe de stratégies. Notons enfin que le sexe du médecin, son lieu de pratique, son type de pratique (tel que l'accueil des patients avec ou sans rendez-vous) et ses responsabilités administratives influencent significativement le degré d'acceptation des stratégies proposées.

Comme ces deux études le démontrent, la collaboration entre les omnipraticiens et les psychiatres peut s'accomplir par des stratégies spécifiques. Ces deux catégories de médecins expriment en général une opinion positive par rapport aux stratégies destinées à améliorer la communication mutuelle et à l'organisation des activités de FMCP (fondées sur la pratique), conçues pour les omnipraticiens. D'après leur perception, l'implantation de ces stratégies dépendrait d'initiatives locales et provoquerait un bouleversement minimal des pratiques cliniques bien établies. Toutefois, les stratégies impliquant, pour les omnipraticiens, un meilleur accès aux psychiatres consultants au sein des services externes de première ligne sont

moins biens accueillies, particulièrement par les psychiatres. On croit que l'implantation de ces stratégies requerrait des changements majeurs des pratiques cliniques pour la plupart des omnipraticiens et psychiatres. Ces stratégies tendent à se limiter à certains groupes de médecins qui partagent déjà entre eux les caractéristiques facilitant une étroite collaboration. Finalement, ce projet de recherche a permis d'identifier des stratégies susceptibles de promouvoir la collaboration entre omnipraticiens et psychiatres et ainsi leur permettre d'offrir une réponse plus adéquate aux besoins des patients souffrant de troubles mentaux.

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To all, a heartfelt "obrigado!"

This work is dedicated to all those individuals who express their psychic suffering through challenging somatic metaphors still so difficult to understand and heal.

INTRODUCTION

The exploratory research project described below was carried out with the overall objective of identifying strategies which may enhance collaboration between general practitioners (GPs) and psychiatrists at the primary care level according to physicians' views. As exploratory research*, this project fills a gap in the emerging knowledge concerning the improvement of collaboration between GPs and psychiatrists through a combination of qualitative and quantitative research methods. Two consecutive studies were conducted: one qualitative (first), the other quantitative (second).

The qualitative study was conducted in eastern Montreal between 1998 and 1999. The general study objective was to identify the key strategies which may increase collaboration between GPs and psychiatrists in the delivery of mental health services in primary care settings. In order to achieve this objective, information was collected on working patterns involving GPs and psychiatrists, their perceived roles and respective expectations, the barriers to collaboration, and suggestions for improvement of collaborative service delivery. All information was gathered from a purposefully selected sample of five GPs and five psychiatrists. Ten individual in-depth interviews and one focus group session were conducted. The data treatment process consisted of content analysis and was guided by a pre-established coding system. A description of this qualitative study and of its partial results (suggestions for improved collaboration) is presented in the article *"Strategies of Collaboration*

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* For further information on exploratory research see Van der Maren, J-M. Méthodes de Recherche pour l'Éducation. 2nd edition. Montreal: Les presses de l'Université de Montréal, 1996; pp. 191-200.

between General Practitioners and Psychiatrists: A Qualitative Study on Physicians' Views."

The quantitative study consisted of a survey which was conducted in the fall of 2000 in the metropolitan area of Montreal. The survey had two objectives. The first was to collect the opinions of both GPs and psychiatrists practicing in Montreal with respect to strategies for improving collaboration between them at three levels - communication, Continuing Medical Education (CME) for GPs in psychiatry, and on-site collaboration in primary care settings. The second was to identify demographic and practice characteristics of physicians associated with the acceptance of such strategies. Based on the results of the qualitative study, a questionnaire was specifically designed to elicit physicians' agreement or disagreement with the strategies of collaboration and was mailed to 203 GPs and 203 psychiatrists randomly selected. The process of data analysis was conducted by using computer software SPSS for Windows, version 9.0, and consisted of bivariate and multivariate statistical analyses. The survey response rate was 86% for GPs and 87% for psychiatrists. A detailed description of the survey is presented in the article "S*trategies of Collaboration between General Practitioners and Psychiatrists: A Survey of Practitioners' Opinions and Characteristics."*

A LITERATURE REVIEW ON THE INTERFACE BETWEEN PSYCHIATRISTS AND GENERAL PRACTITIONERS

In their seminal work, *Psychiatric Illness in General Practice,* Shepherd and colleagues (1) some 40 years ago demonstrated that psychiatric disorders were a common reason for consulting a general practitioner in England. At that time they also highlighted the importance of general practitioners (GPs) as mental health providers and suggested that their roles as such should be strengthened instead of expanding the psychiatric sector. This work was the starting point of various studies investigating the "hidden psychiatric morbidity" in primary care settings.

In 1978, Regier and colleagues* (2) called primary care "the de facto mental health care system." This proclamation was based on the following epidemiological data from that period: a) at least 15% of the American population was affected by mental problems each year; b) of these mentally compromised people, only one in five received psychiatric assistance in the specialized sector; and c) three in five individuals with psychiatric problems were seen in the primary care/outpatient medical sectors (general medical settings). In essence, more than half of those estimated to have mental

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* On the prevalence of psychiatric disorders and the help-seeking process of mentally ill individuals, see **1)** Kessler RC, McGonnagle A, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen HU, Kendler KS. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. Archives of General Psychiatry 1994; 51: 8-19; **2)** Howard KI, Cornille TA, Lyons JS, Vessey JT, Lueger RJ, Saunders SM. Patterns of mental health service utilization. Archives of General Psychiatry 1996 53: 696-703; **3)** Fournier L, Lesage AD, Toupin J, Cyr M. Telephone surveys as an alternative for estimating prevalence of mental disorders and service utilization: a Montreal catchment area study. Canadian Journal of Psychiatry 1997;42: 737-43.

disorders in the United States were identified or received their psychiatric care in general medical settings. It is quite likely that these numbers at the primary care level have increased due to the current emphasis on shifting resources from hospitals to primary care and community settings.

GPs are often the first professionals consulted in the help-seeking process of mentally disturbed individuals (3). Globally they see the majority of patients with mental disorders (4, 5) and play an important role in the delivery of mental health care (6). However, as highlighted by Kates and colleagues (7), GPs alone cannot provide mentally ill individuals with all the care they need. Collaboration with other professionals, especially with psychiatrists, is widely recommended (7-9).

In the following sections an overview of psychiatric disorders in community and primary care settings will be presented, as well as a description of models of collaboration between GPs and psychiatrists.

Psychiatric disorders in community and primary care settings

The prevalence of mental disorders in the community is reported to range from 13-29.5% (10). This wide range of prevalence rates may be explained by methodological differences among the studies, in terms of instruments, number of disorders studied, and period of reference for the prevalence rates. According to the United States Surgeon General's report on mental health (11), anxiety disorders are the most frequently occurring mental

disorders. They encompass a group of conditions that share pathological anxiety as the principal common disturbance. The one-year prevalence of such disorders is over 16% in the U.S. The most prevalent anxiety disorders are a) general anxiety disorder, b) panic disorder, and c) phobias.

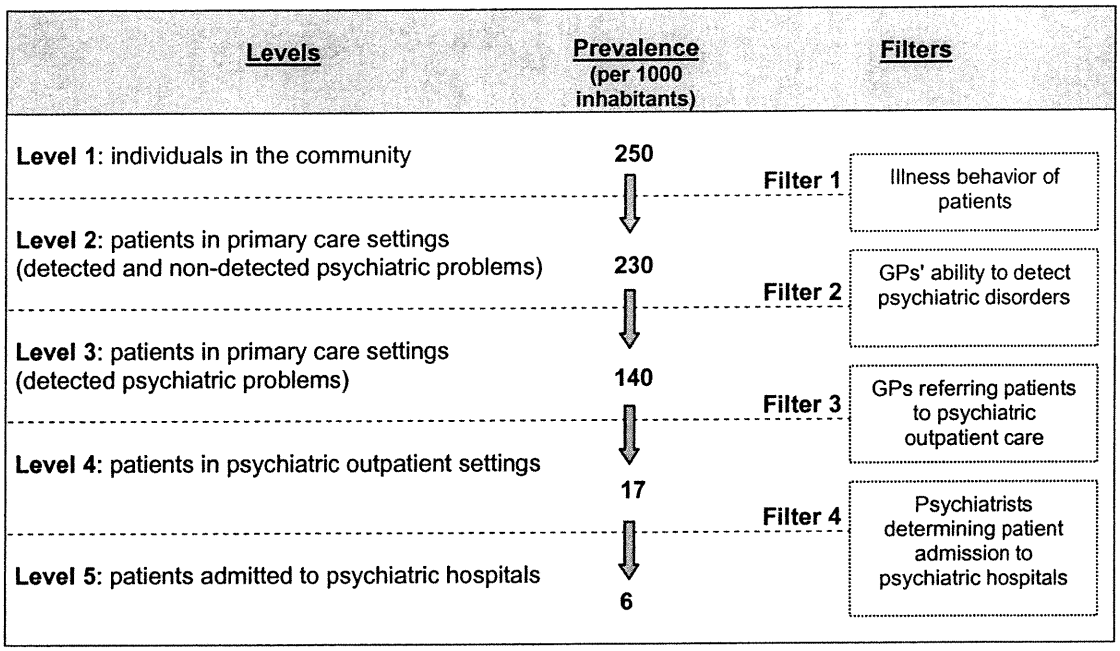
Some mood disorders are quite frequent as well. Data was collected in the National Comorbidity Survey, a nationwide study of the American population, ages 15-54 years, that was designed to estimate the prevalence, risk factors, and consequences of psychiatric morbidity and comorbidity. Blazer and colleagues (12) analyzed this study's data and estimated the following prevalence rates of major depression in the general population: a) the prevalence of current (30-day) major depression was 4.9% and b) the lifetime prevalence of the same disorder was 17.1%. In Canada surveys were conducted in community samples in a) Quebec (10), b) Ontario (13), and c) Alberta (14). The following prevalence rates of major depression were estimated respectively: a) Quebec - 29.6% (lifetime) and 7.7% (six-month); b) Ontario - 4.1% (one-year); and c) Alberta - 8.6% (lifetime). Anxiety and depressive disorders together are responsible for between one quarter and one third of all primary health care visits worldwide (15).

Somatoform disorders and substance abuse disorders are also common psychiatric disorders in primary care settings. The prevalence of alcohol abuse ranges from 5-15%, with higher prevalence rates in urban areas of lower socioeconomic status. Current and lifetime substance abuse

disorders are more prevalent in patients with major depression and other depressive disorders (16).

Based on several primary care studies, Goldberg and Huxley (17) outlined the pathway to psychiatric care through an epidemiological model. They explain the model through five levels and four selectively permeable filters among the levels (see Table I). Each level represents a different population of individuals. Level 1 represents individuals in the community. Level 2 is represented by psychiatric patients (detected as such or not) receiving care from primary care physicians. The first filter is located between the first and second level and is represented by the illness behaviors of patients (that is, severity and type of symptoms, attitudes of relatives, availability of medical services, and ability to pay for treatment). Level 3 is represented by patients whose psychiatric problem is identified by their primary care physician. The second filter is represented by the primary care physician's ability to detect psychiatric disorders among his or her patients in level 2. Level 4 is represented by patients receiving care from psychiatrists in out-patient clinics and private practices. The third filter is represented by primary care doctors who determine the patients being referred for outpatient psychiatric care. Level 5 is represented by patients admitted to psychiatric hospitals (as the authors point out, these are the psychiatric patients mentioned in national statistics). Psychiatrists determining the patients admitted to psychiatric hospitals represent the fourth filter.

Table I: Pathways to psychiatric care (modified from Goldberg and Huxley 1980)

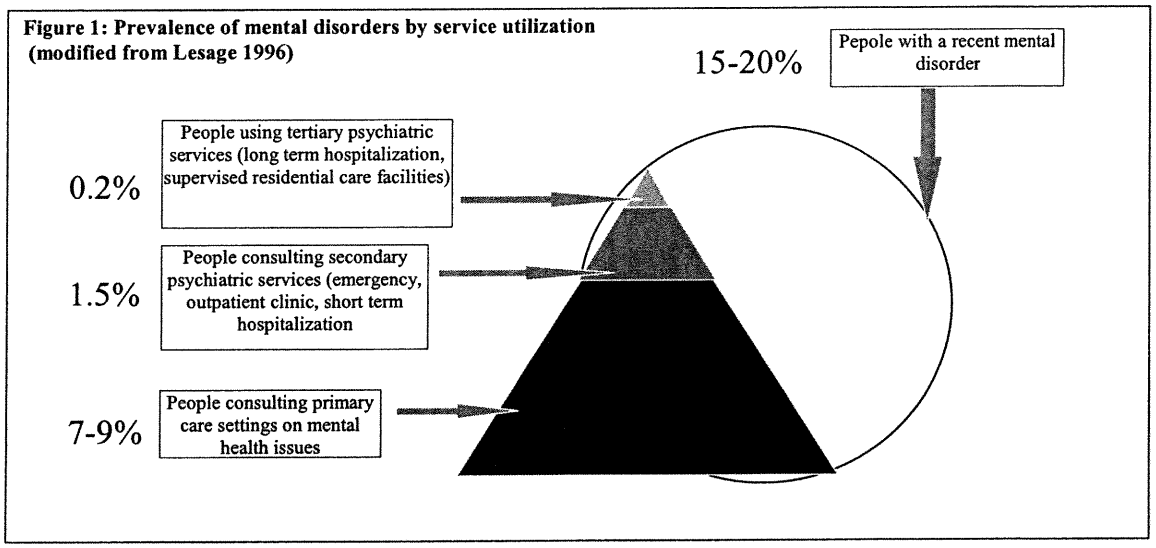


These authors have shown that some 250 individuals per 1000 at risk per year are detected as showing significant psychiatric morbidity in community surveys at level 1. Some 230 mentally disturbed individuals receive care in primary care settings (level 2). On average, GPs recognize some 140 individuals as suffering from psychiatric morbidity at level 3. Of those only 17 patients are referred to psychiatrists at level 4. Finally, 6 patients are admitted to a psychiatric unit or hospital at level 5. It is worth noting that the factors that decrease the prevalence of 230\1000 at level 2 to 17\1000 at level 4 operate in the GPs' offices. Therefore, GPs play a decisive role in managing the help-seeking process of mentally ill individuals.

Lesage (18) conducted a two-tiered epidemiological community survey to measure the prevalence of mental disorders and to collect information on

the help-seeking process of mentally ill individuals in Eastern Montreal. First, a representative sample of 893 adults was surveyed (DISSA/DSM-R-III) by phone. Then 109 individuals from that sample were subjected to clinical interviews. The results of the study were compatible with the epidemiological model proposed by Goldberg and Huxley, which inspired the model presented below (Figure 1). This model confirms the following: a) there is a high prevalence of psychiatric disorders in the community; b) many mentally ill individuals do not seek care; c) those who seek treatment use primary care services; and d) only a few mentally ill individuals use specialty service.

Figure 1: Prevalence of mental disorders by service utilization (modified from Lesage 1996)



Lesage also reported the following reasons why people (109 respondents) do not consult a physician on mental health issues: a) belief that they can solve their mental problems by themselves (66%); b) belief that the problems are transient and will be solved by themselves (50%); c) perception that consultation is too expensive (47%); d) lack of knowledge on where to

seek help (34%); e) past experience with consultation that was perceived to be ineffective (32%); f) inability to secure an appointment (9%); g) fear of being hospitalized against will (3%). The author notes that respondents could choose more than one of these reasons. Accordingly, the addition of percentages exceeds 100%.

American researchers also identified factors related to the help-seeking behavior of mentally ill individuals. Coryell and colleagues (19) compared individuals with depression who did not seek treatment with individuals who did. They found that the likelihood to seek treatment is increased by the following factors: a) age (older individuals); b) characteristics of the depressive episode (such as cessation of role-functioning, suicidal thoughts, duration of the episode); and c) family member treatment for an affective disorder (major depressive or bipolar I disorders).

Comorbidity

Several studies have reported comorbidity among psychiatric disorders as well as comorbidity between them and somatic disorders. Hilty and Servis (16) summarize the results of studies on comorbid major depressive disorder and anxiety disorders. Of patients meeting criteria for a major depression, 75% had a lifetime history of comorbid anxiety disorder. This combination is so frequent (5.1-6.6% prevalence rate) that a mixed anxiety-depression disorder was proposed for patients who do not meet the criteria for major

depression or generalized anxiety disorder but who have a substantial number of clinically relevant symptoms. This mixed disorder is listed in the ICD-10 but not in the DSM-IV. The U.S. Surgeon General's Report on Mental Health (11) cites studies which confirm the frequent association between major depression and anxiety. About one-half of those with a primary diagnosis of major depression also have an anxiety disorder. The comorbidity of anxiety and depression is so frequent that it has led to theories of similar etiologies. In the same report the comorbidity between mood disorders and substance use disorders is mentioned as well. Substance use disorders are found in 24-40% of individuals with mood disorders in the U.S. Without treatment, substance abuse worsens the course of mood disorders. Personality disorders and several somatic disorders (such as cancer, neurological diseases, cardiac diseases, rheumatoid arthritis, etc.) are also comorbid disorders of major depression (11, 20). Rouchell, Pounds and Tierney (20A) reviewed studies on the impact of major depression on morbidity or mortality of cardiovascular disease and stroke. They presented the following results based on their review: a) major depression was the best predictor of myocardial infarction, angioplasty, and death during the 12 months following cardiac catheterization; b) major depression in hospitalized patients following a myocardial infarction was an independent factor for mortality at 6-month follow-up, and c) patients with depressive episodes following a stroke were 3.4 times more likely to die during a 10-year period than patients without such episodes.

Burden and costs

Psychiatric disorders cause marked human suffering and disability to a large number of patients, especially in primary care settings (16, 4). The *Global Burden of Disease* study, conducted by WHO, the World Bank and Harvard University, has been discussed in two recent major American reports (11, 21). It calculated the disease burden through a measure called Disability Adjusted Life Years (DALYs). This expresses years of life lost to premature death and years lived with a significant disability in terms of severity and duration. It allows comparison of the burden of disease across many different disease conditions. Major depression, for example, by this measure, ranked second only to ischemic heart disease in magnitude of disease burden. Patients with major depression are high utilizers of medical resources (22, 23) and quite often are undiagnosed as psychiatric cases. Such patients, particularly those with somatic complaints, tend to a) make more visits to primary care settings than non-depressed patients; b) receive prescriptions of multiple drugs with the overuse of anxiolytics and analgesics; c) undergo unnecessary medical tests and hospitalizations. The high utilization of services and the increased number of sick days (absenteeism) have very important social and economic consequences (4), especially . The economic impact of depression in all settings is estimated to exceed US $43 billion per year in the U.S. (16).

Despite the harming consequences of psychiatric disorders, the most prevalent ones, such as depression and anxiety disorders, can be effectively treated. However, too often they are not recognized or treated, especially in primary care settings (24).

Detection of psychiatric disorders in primary care settings

There are numerous factors that should be considered barriers to the recognition and treatment of psychiatric disorders in primary care settings. As states Cole and Raju (25), they all must be taken into account, rather than simply focusing on improving knowledge and skills of primary care physicians.

Patient factors

Patient expression of psychiatric symptoms (psychological vs. somatic complaints) and patient attitudes toward mental health issues are important barriers to the recognition and treatment of psychiatric disorders in primary care settings. Some patients do not recognize they have symptoms of a psychiatric disorder and instead they focus on somatic etiologies of their symptoms. Lipkin (26) explains that those patients see a GP without acknowledging their complaints as psychological. They wear the "many-colored somatic robes of physical complaints," he says. In primary care settings somatization refers to at least three overlapping, but conceptually distinct (27) groups of psychiatric disorders: depressive, anxiety and

somatoform disorders. According to Goldberg and Bridges (28), GPs are more likely to detect and treat a patient's mental disorder when it is defined psychologically, rather than in somatic terms. These authors found that patients with somatic complaints - "somatizers" - are more hostile to mental illness on various attitude scales. In addition, if they had symptoms of either depression, neurasthenia or panic, they would be less likely to consult a doctor because of such symptoms or to mention them to him or her.

In a study of 700 patients attending hospital family medicine units, Kirmayer and colleagues (29) differentiated three categories of "somatizers" based on symptom attributions among patients with depression or anxiety disorder: a) initial somatizers, b) facultative somatizers, and c) true somatizers. Only the latter category of patients rejected any connection between their psychiatric disorder and concomitant somatic symptoms. The other two categories of patients acknowledged psychosocial causes to their symptoms when they were asked. It is worth noting that psychiatric case detection among GPs can also be associated with higher initial severity of psychopathology, occupational disability in occupational role, as well as with reason (psychological versus somatic) for medical encounter (29A).

Furthermore, in the first part of a two-tiered study involving 4098 patients and 91 GPs, Marks and colleagues (30) identified demographic characteristics of patients associated with high rates of psychiatric case detection. Unemployment, female gender, and marriages which ended by separation, divorce or death are factors associated with an increased

likelihood of the GP detecting a psychiatric disorder. In addition, GPs are more likely to detect psychiatric disorders in patients whom they have seen more than five times before. However, other characteristics of patients appear to be associated with case underdetection. These characteristics include the 15-24 age group, students, the unmarried, those educated beyond the age of 23, and male patients. The authors explain it is possible that GPs tune their alertness to psychiatric cases in primary care settings according to certain stereotypes. A middle-aged housewife with a broken marriage may be perceived by GPs as a negative stereotype of the psychologically healthy, whereas a young educated bachelor would represent the positive stereotype. As a result, in the latter case a GP would be less alert to the possibility of a psychiatric disorder.

Physician factors

Physician training, attitudes towards psychiatry, communication skills, and personality attributes should all be considered in a physician's ability to detect psychiatric disorders.

Medical school preparation in psychiatry and residency training do not allow ample time for trainees to learn the full range of complex psychiatric nosology and therapeutic options (16). In addition, trainees gain more exposure to hospital settings rather than primary care ones.

Formal medical training is based on a system of values which does not embrace psychiatry. For instance, when a medical student tells classmates or

professors that he or she plans to seek residency in psychiatry, the reaction is often negative (31). Furthermore, some physicians believe that a) mental health problems are not legitimate medical problems, and b) others should manage a patient's mental problems or treat a patient's mental disorders (16).

Most primary care visits last an average of eight to twelve minutes (32). During these visits physicians may limit the dialogue with patients by asking closed-ended, leading or negative questions (33). As a result, physicians miss important information (e.g. emotional state, psychosocial facts) about their patients and are less likely to detect psychiatric disorders.

In the second part of the two-tiered study, Marks and colleagues (30) studied the ability of GPs to detect psychiatric disorders in association with a) GPs' personality attributes (extraversion, neuroticism, and conservatism), b) GPs' attitudes towards psychiatry (that is, treatment of emotional disorders, and role of psychogenic factors in physical illness), and c) GPs' interviewing techniques. Fifty-five GPs completed personality inventories and provided researchers with details about their training and professional background. These GPs conducted 2098 interviews while the main researcher made detailed observations on their verbal and non-verbal interviewing styles. The findings supported the importance of GPs' interviewing style and GP's personality attributes in the detection of psychiatric disorders. GPs, who are interested in psychiatry, express empathy, ask the patient questions about his or her family and problems at home as well as questions with a psychiatric content, are more likely to recognize psychiatric disorders in their patients.

Studying the ability of 45 family practice residents to make accurate ratings of psychiatric disorders, Goldberg and colleagues (34) confirmed the findings that the interviewing style and personality attributes of physicians have an impact on the detection of psychiatric disorders. Self-confident, outgoing physicians with high academic skills tend to detect psychiatric disorders more accurately.

The detection of psychiatric disorders by GPs is an important issue in the delivery of psychiatric services. However, as Tiemens and colleagues (29A) point out, recognition of psychiatric disorders is a necessary but not a sufficient condition for treatment delivery. Increasing recognition, they say, is likely to improve outcomes only if GPs have the skills and the appropriate resources to deliver adequate interventions.

Organizational and financial factors

In addition to the barriers associated with patients and physicians, a number of other challenges contributes to the underdetection and undertreatment of psychiatric disorders. In 1978 WHO called upon the countries of the world, through the Declaration of Alma Ata (34A), to improve primary care as a basic measure to achieve the aim of "Health for All." Ever since, health policies worldwide have tried to implement primary care services and integrate them into the specialized sector (34B). Mental health services have followed this tendency through a long-term process known as "desinstitutionalization." Overall it aims at decreasing the institutionalization of

new patients, dehospitalization of those long term in-patients (reduction of psychiatric beds), as well as diversifying and multiplying psychiatric services in the community (34C).

However, the current organization of mental health services does not allow such services to manage efficiently all the individuals with mental disorders. The epidemiological model presented before is a sound estimation of patient need for care. The prevalence rates and the pattern of health service utilization illustrated by the model are astonishing. Lecomte and Lesage (35) state it is a "tâche colossale" to provide all mentally ill individuals with the care they need.

Collaboration with primary care professionals (physicians, nurses, psychologists, social workers, etc.) and community resources (such as AA) would help to achieve this task (18). However, the coordination and integration of services between the specialty mental health sector and the primary care sector is yet to be accomplished (7).

The following problems were mentioned by participating physicians in our qualitative study: a) perceived shortage of mental health professionals (including psychiatrists); b) poor distribution of human resources (most psychologists work in the private sector; many GPs work in walk-in clinics); c) unavailability of structured psychotherapy in several primary care settings; d) access to psychotherapy in psychologists' private practices only through private health insurance plans; e) long waiting lists to consult a family physician or a psychiatrist (for patients who were referred); f) poor

collaboration between the primary care sector and the specialty sector (most psychiatric services do not recognize primary care physicians' roles as mental health providers); g) medical-legal problems (for instance, GPs' skills to conduct a psychiatric evaluation are questioned; they need psychiatrists to validate their assessment of a patient's psychiatric condition, so that the patient's work leave or return is approved by a health insurance company). Most of these problems were discussed in the document *"Shared Mental Health in Canada"* (7).

Reimbursement systems can also prevent individuals from receiving psychiatric care. The fee-for-service mode of remuneration, for example, allows physicians to select the medical services which are more profitable. Individuals with health problems that can be solved fast will bring physicians more income. The larger the number of patients seen, the larger is the amount of remuneration. As a result, individuals who require more time to solve their health problems, such as individuals with psychiatric problems, may not receive adequate care. Most physicians in Quebec (as well as in many industrialized countries) are paid on a fee-for-service basis (36).

Models of collaboration

Collaboration throughout this section is used to mean shared mental health care. This is defined in the document *"Shared Mental Health in Canada"* (7) as follows:

> *"(...) 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 (...). (...) the key principles that should guide collaborative activities (...) [are]: 1) improving communication; 2) building new linkages between family physicians and psychiatrists and psychiatric services; and 3) integrating psychiatrists and psychiatric services within primary care settings (...)."*

This document was prepared by a joint working group of the Canadian Psychiatric Association and The College of Family Physicians of Canada. It is the first most relevant report on shared mental health care published in Canada. "Shared care" is the Canadian way of naming models of collaboration between GPs and psychiatrists at the primary care level.

As outlined in the document (7), in theory the general practitioner and the psychiatrist are natural partners in the mental health care system. Their work together is a key step towards a better-integrated and more efficient health care system. Too often, however, they fail to establish a collaborative working relationship. Two of the main reasons for such failure are a) the difficulty of access to psychiatric consultative or treatment services and b) the poor communication between GPs and psychiatrists in the referral process as well as a lack of personal contact between them (7, 37-39). Thus, there is a need to improve this relationship, especially in the current climate of

realignment of health services with an emphasis on shifting resources from hospital to community settings (7, 40).

Assessing the expansion of specialized services in the years 1970-75 in England (the landmark country for models of collaboration between the specialty sector and primary care settings), Williams and Clare (41) identified three models of collaboration between GPs and psychiatrists - the "replacement" model, the "increased throughput" model, and the "liaison-attachment" model.

In the "replacement" model the psychiatrist replaces the GP as doctor of first contact, and provides specialty care directly to patients. (Although being rapidly substituted by managed care's integrated models of collaboration, this model has been representative of the American health system for years, and is also known as the American bypass where individuals can consult medical specialists without consulting primary care physicians.)

The "increased through-put" model consists of GPs being encouraged to make more referrals to specialty services, so that patients receive better services. However, as the authors explain, both these approaches would swamp psychiatric services that could never expand to meet such demand resulting in the exclusion of individuals from any form of psychiatric care.

The third model, the "liaison-attachment" model involves on-site collaboration between psychiatrists and GPs in primary care settings. Psychiatrists move their hospital-based practices into primary care settings to collaborate directly with GPs. Mitchell (42) explains that in this model both

psychiatrists and GPs work together with other members of the primary health care team. It emphasizes the psychiatrist's role as an educator in mental health issues and involves him or her in training and supervision of GPs and other primary care professionals.

Strathdee and Williams (43) carried out a survey to obtain information about the working patterns of psychiatrists at the primary level. Among 109 psychiatrists who answered the survey, the authors identified three main working patterns, which appear to have emerged through spontaneous initiatives of certain psychiatrists and GPs rather than through a "central organizing body."

The first pattern was the "shifted out-patient clinic" one, which was adopted by 64% of the respondents. It consisted of psychiatrists transferring their practices from psychiatric outpatient clinics to primary care settings. Psychiatrists stated that the stigma attached to mental illness would be lessened when patients are seen in primary care settings rather than in psychiatric outpatient clinics. Mitchell (42) points out that this working pattern may not improve contact with GPs.

Twenty-eight per cent of the surveyed psychiatrists adopted the second pattern, which was the "consultation" pattern. It consisted of psychiatrists mainly assessing patients individually or with GPs, and giving advice to GPs on the treatment of non-referred patients. For some psychiatrists (psychotherapists) this working pattern consisted of giving Balint-type seminars and studying the doctor-patient relationship with GPs. The third

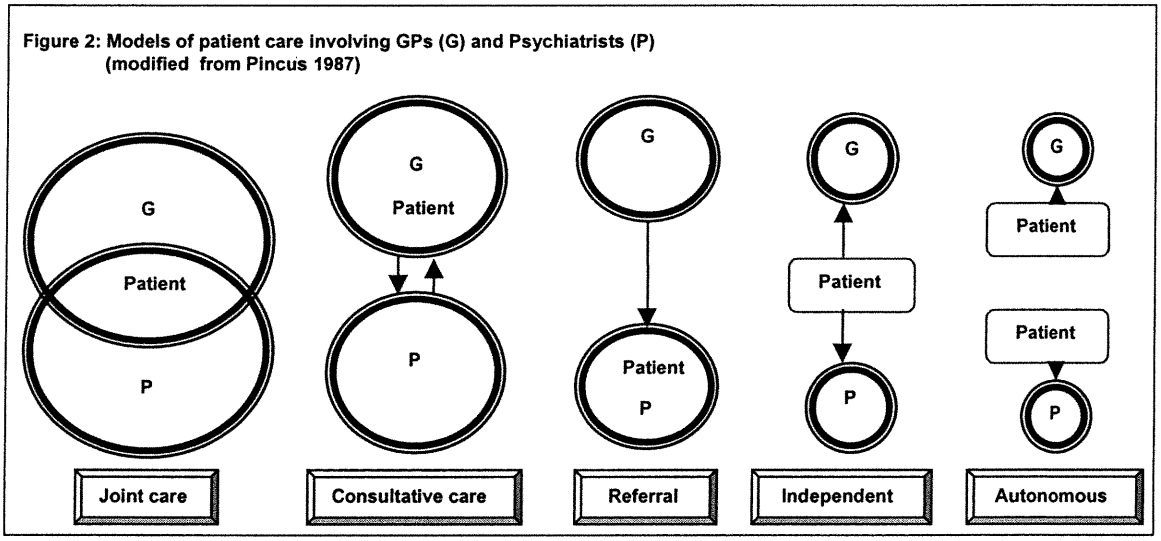
pattern was adopted by a minority of psychiatrists and consisted of the liaison-attachment model described above.

In a very concise and informative introduction about the models of collaboration involving psychiatrists and GPs in primary care settings, Barber and Williams (44) outline another model of collaboration. It combines psychiatrists' clinical tasks in the "consultation" pattern with psychiatrists' tasks of training and supervision in the "liaison-attachment" model, forming the "consultation-liaison" model. In this model psychiatrists participate in the management of several patients and share skills and knowledge with health professionals.

According to Lipowski (45), the consultation-liaison model may bring significant changes in the way psychiatry is practiced due to the type of training, skills and professional attitudes that it requires from psychiatrists. He notes that liaison psychiatrists are often in contact with seminal developments in clinical practice, education, research, and modes of health care delivery in both general medicine and psychiatry.

Pincus (46) developed a set of conceptual models of collaboration between general health and mental health systems of care. He observed that these models of collaboration vary according to the degree of emphasis on one or another of three groups of elements. Contractual elements constitute one group, involving issues such as the mechanisms of patient referral, the means of transferring clinical information between the two systems of care, access to patient records, and the assurance of follow-up care for the patient.

Another group consists of functional elements. These include any possible combination of services, ranging from diagnostic evaluation through various models of short and long term treatment to substance abuse treatment. The last group encompasses educational elements. These include basically the aspects of the relationship between GPs and psychiatrists which reinforce GPs' knowledge and skills in mental health, and, by the same token, increase psychiatrists' understanding of general health issues relevant to patient care.



As seen in figure 2, Pincus (46) also identified different ways in which psychiatrists and GPs provide care to patients:

a) joint care - both the GP and the psychiatrist are involved in patient care, which may include joint sessions with the patient and frequent communication between the physicians;

b) consultation - the GP is the principal provider of care to the patient, and may request consultation from the psychiatrist; some communication between providers may be maintained;

c) referral - the psychiatrist provides most care to the patient with limited communication with the GP;

d) independent - both the psychiatrist and the GP provide care to the patient with no communication between them;

e) autonomous - patient care is provided by either the GP or the psychiatrist with no involvement between them.

The models described above have inspired physicians in different countries. In the United States, for example, the Rochester program (47) provided several local GPs with access to a consulting psychiatrist (and to non-medical therapists) in primary care settings. As a result, several benefits were reported: a) patients who would not attend care in psychiatric services received mental health care in primary care settings (mitigating the stigma of mental health care); b) communication was improved between mental health staff and primary care providers (better coordination of care); and c) primary care providers increased their knowledge about mental health diagnosis and treatment (professional development). In Australia (48) and in Israel (49) models of collaboration similar to the ones described above have also been implemented.

In Canada, the McMaster approach, a pioneer model of collaboration, combines the access to psychiatric consultation with the provision of

psychiatric training for GPs in their primary care offices. It emphasizes the importance of understanding the needs of general practitioners and helping them make optimum use of available psychiatric services (37, 50). Kates and colleagues have described their different ways in applying the McMaster approach at the primary care level: case reviews (51), telephone back up (52), and visits to primary care practices on a regular basis (53). The benefits of this collaborative approach are reported to be shared by patients, physicians, and the health care system.

It is worth noting that in Canada groups of physicians involved in models of collaboration between GPs and psychiatrists have also reported their satisfactory practices. In Ontario, Turner and Sorkin (54) from the Toronto Doctors Hospital have outlined their implemented strategies of shared care with local GPs at the psychiatric consultation level. In Quebec, twenty years ago the department of psychiatry of Hôpital Sainte-Croix in Drummondville (55) developed a collaborative model with local GPs to overcome the shortage of psychiatrists. The model emphasizes the exclusive role of psychiatrists as available consultants to GPs. In addition, the department of psychiatry in Drummondville offers a special training in psychiatry for GPs on the following topics: main psychiatric syndromes, psychopharmacology, psychotherapeutic approaches, and some legal aspects of psychiatry. In this context GPs express their satisfaction with the access to psychiatric consultation.

The interface between psychiatrists and GPs, briefly reviewed above, provided to a great extent the theoretical background of this research project.

In the following sections an overview of qualitative and quantitative research approaches is outlined to highlight the complexity of combining these approaches.

THE QUANTITATIVE-QUALITATIVE DUALISM: TOWARDS A COMBINATION OF METHODS

The studies conducted in this project combined qualitative and quantitative research methods. It is important to comprehend the basic differences involved in the quantitative and qualitative approaches to research, which go beyond the methodological and indeed are grounded in the philosophical.

For at least two centuries scholars have debated quantitative-qualitative dualism. It can be traced back to the seventeenth and eighteenth-century controversies on the ideas of great philosophers such as Descartes and Kant (56). As Groulx (55) explains, the academic debate surrounding quantitative-qualitative dualism has been traditionally carried out by two sociological schools: the Columbia School and the Chicago School. These schools have pushed forward other forms of dualism: survey vs. monograph and statistical analysis vs. interpretative analysis.

Academics worldwide continue to engage in this debate. Several books on science methodology present at least one chapter about this dualism. Most of them reinforce dualism by pointing out that it is founded on substantive

differences in the two paradigms (57,58). However, advocates for the integration of quantitative-qualitative approaches can be identified in various disciplines from sociology to epidemiology (57). Often these advocates offer the rationale for integration by pointing to all the benefits to research activities which could emanate from the combination of qualitative and quantitative methods of data collection.

In the following sections a brief historical perspective of the quantitative-qualitative dualism is presented along with a description of its underlying paradigms. The realist paradigm which determines quantitative methods and the constructivist paradigm which determines qualitative methods (59) will be reviewed. Then quantitative and qualitative methods will be outlined and their combination is discussed.

A brief historical perspective

According to Hamilton (56), René Descartes (1596-1650) through his work, "Discourse on Method" (1637), was the founder of the quantitative research field. Descartes argued that the real search for truth lies in objectivity as expressed in mathematics. He believed that the principles of natural philosophy had to be embedded in "certainty and self evidence." These beliefs are still very strong today. Guba and Lincoln (58) explain that mathematics is often termed the "queen of the sciences," and disciplines such as physics and chemistry which are specifically given to easy quantification

are generally known as “hard.” Less quantifiable fields, such as social sciences, are termed “soft.” Indeed the more a research field lends itself to quantification, the more it is perceived to be scientifically mature. Hamilton (56) argues that Immanuel Kant (1724-1804) was the founder of the qualitative research field. He explains that Kant's ideas published in the "Critique of Pure Reason" (1781) broke from Cartesian objectivism and set the basis for qualitative thinking. Kant believed that human perception emerges from the senses (e.g., sensitive receptors and afferent nerves), and also from the "mental apparatus" which organizes the incoming sense information. He emphasized that the integrative dimension of the CNS plays a significant role in the organization of human perceptions. For Kant, human knowledge is ultimately based on understanding, an intellectual state that is more than just the consequence of experience. Thus, human claims about nature cannot be independent of an "inside-the-head" process of the knowing subject (56). Based on this, one can easily understand the underlying fallacy of the famous saying, "Numbers speak for themselves.”

Paradigmatic perspectives

In his specialized dictionary, Schwandt (60) presents the following definition for the term "paradigm" based upon Thomas Kuhn's (1922-1996) monograph, *The Structure of Scientific Revolutions:*

> "On one hand, a paradigm refers to a type of cognitive framework - an 'exemplar' or set of shared solutions to substantive problems used by a very well-defined specific community of scientists (...) both to generate and to solve puzzles in their field. (...) On the other hand, Kuhn used the term to mean a 'disciplinary matrix' - commitments, beliefs, values, methods, outlooks, and so forth shared across a discipline (...)."

Guba and Lincoln (58) view paradigm as a set of beliefs that deals with ultimate or first principles. They explain that these beliefs represent a worldview that defines, for an individual, the nature of the world, the individual's place in it, and the range of possible relationships to that world. These authors add to this definition that the beliefs are accepted simply on faith, however "well argued," they say. It is impossible to establish their ultimate truthfulness.

In short, paradigm can be understood as a conceptual framework that reflects the ideas, beliefs and values of a group of academics. It represents their worldview and their rationale to address problems and solutions in the process of producing knowledge.

In a very elucidating article, Levy (59) presents a concise overview of the basic differences involving the realist paradigm and the constructivist one. Guba and Lincoln (58) also present a comprehensive and detailed description of several paradigms including these two. A brief compilation of both paradigms as described in the work of these authors is presented below. Both paradigms are compared according to three of their distinct and intertwined fields - epistemological, methodological, ontological.

Epistemological field

This field describes the relationship between the researcher and his or her study object (the knower and what can be known).

Realistic paradigm

The principal realistic postulate in this field is that the researcher is a completely detached being from the phenomenon under observation. This postulate supports an objectivist and dualist epistomology characterized by the Cartesian interaction of body and mind. The knower must be one of objective detachment in order to be able to discover "how things really are" and "how they really work." The epistemology of the realistic paradigm is based on the belief that the researcher is neutral.

Constructivist paradigm

The researcher and the object of investigation are assumed to be interactively linked so that the findings are literally created as the investigation proceeds. Accordingly, it is believed that the researcher serves in a creator role and is not neutral.

Methodological field

This field concerns the techniques and procedures that can help the researcher find out whatever he or she believes can be known. These tools are used in the reflection, representation, reconstruction and creation of problems and solutions. They must be used in accordance with the epistemology and ontology of each paradigm.

Realistic paradigm

Given that the researcher must be "neutral," all factors which interfere with the investigation (e.g. values, analytical views, actions) must be as much as possible controlled to ensure that the researcher does not influence the phenomenon being studied or is not influenced by it. Accordingly, even the suspicion of an influencing action triggers employment of specific strategies to minimize or eliminate the influence in either direction. Since the prescribed procedures are rigorously followed, replicable true results are achieved.

Constructivist paradigm

The principle of interaction is recognized and valued. Individual (intramental) constructions can be elicited and refined only through interaction between the researcher and participants of a investigation. Guba and Lincoln (58) point out that these varying constructions are interpreted using conventional hermeneutical techniques, and are compared and contrasted

through a dialectical interchange. The final aim is to distill a consensus construction that is more informed and sophisticated than any of the previous constructions including those of the researcher.

Ontological field

This field defines what is the form and nature of reality and what there is that can be known. It defines the spectrum of entities that can be known in the research process.

Realistic paradigm

The realistic ontology affirms that there is only one reality, which is independent, pre-existent and ordered. Therefore, what can be known about it is "how things really are" and "how things really work." Then only those questions that relate to matters of "real" existence and "real" action are admissible. Other questions, such as those concerning matters of moral significance (e.g. individual or group values), fall outside the realm of a legitimate research process. All discoveries about a certain entity (object) are strictly isomorphic in a singular and true reality. This means that one fact observed in one place should be observed elsewhere the same way.

Constructivist paradigm

For the constructivists, there are multiple realities which are accessed in the form of numerous, intangible mental constructions, socially and experientially based. These constructions are local and specific in nature, although some of their elements are shared among many individuals and even across cultures. The form and contents of such constructions depend on the values and perceptions of one individual or groups of individuals holding them. Constructions are not isomorphic . They are alterable, as are their associated realities. They are in dynamic change constantly. Therefore, constructivists do not see these constructions as universally "replicable."

The choice of a paradigm: doubt and belief

Any given paradigm represents simply the most informed and sophisticated view that its proponents have been able to devise, according to the epistemological, ontological, and methodological assumptions of the paradigm. The sets of information produced in any paradigm are always human constructions. They are all inventions of the human mind and hence subjected to human error. No construction can be incontrovertibly right (58).

Inspired by the work of Charles Pierce, William James and John Dewey, Levy (59) attributes the choice of one paradigm to belief. To support this statement, he describes the relationship between belief and doubt. Doubt produces a state of discomfort and uncertainty in individuals. This stimulates

the individuals to seek an idealized state of certainty, e.g., faith in something. This search for certainty can explain why realism has been so popular. Realism has contributed to the construction of a system of stable beliefs and routine actions. This stability is expressed with factual and measurable certainties. The results of realist investigations are perceived as isomorphic to a pre-existent reality of such sort that doubt is hidden. One can also argue that therein lies one of the principal reasons why constructivism has remained as a second class paradigm. Constructivism believes in the importance of permanent doubt. Hence, it is a system of beliefs in a constant state of change which influences our vision of the world and ourselves.

Combining quantitative and qualitative methods

As presented above, quantitative-qualitative dualism stems from quite distinct philosophical assumptions and has fueled a heated debate on whether or not these two different realms can be united. Despite the strong opinion of those who argue against such union, increasingly investigators adopt research designs combining qualitative and quantitative methods.

Quantitative and qualitative methods (research designs)

Streiner and Goering (61) explain that quantitative research methods involve different techniques, which range from in vitro examination of nerve

endings through brain imaging to community surveys and randomized, controlled clinical trials. Each of these techniques helps to answer specific research questions. Similarly, several qualitative research methods can be identified and are available to the researcher. None is useful in all situations, but collectively the research methods are capable of addressing a wide range of problems.

Tesch (62) considers qualitative research methods any research method that uses qualitative data. She defines qualitative data as any information the researcher gathers that is not expressed in numbers. Accepting this definition, the range of qualitative data includes words (text), drawings, paintings, photographs, films, videotapes, music, and sound tracks if used for research purposes. There are almost no limits to the human creations and productions one could study. She points to researchers who have even worked with household garbage! As a result, more than 40 types of qualitative research methods, considering just words as data, are cited in her book (such as action research, case study, Delphi method, ethnography, grounded theory).

Given so many options of research methods, which one (s) should be used? That depends on the problem, question (s), and objectives of the investigation. Fink (63) advises in a very pragmatic way that when research questions involve how many or how much, quantitative methods should be adopted. However, when researchers intend to understand (how) a social

process, a context of life, etc., qualitative methods would be more appropriate (61).

Data collection techniques

Creswell (64) describes four basic types of data collection techniques in the qualitative area: a) observational methods (ranging from non-participant to participant); b) interviews (ranging from structured to open-ended, individual or group interviews); c) document analysis (ranging from private to public); and d) audio-visual techniques (e.g., film, videos, photography). Interviews are the favorite data collection technique of qualitative researchers (65). Qualitative inquiries often range from informal and unstructured interaction (e.g., ethnographic field interview) to a more formal and semi-structured interview that covers a set of pre-selected points (61). Two forms of interviewing techniques have been included in mixed (qualitative and quantitative) research designs: in-depth individual interviews and/or focus group sessions (66, 67).

Quantitative methods of data collection used in psychosocial studies (such as surveys) also include interviews. Self-administered instruments are used, too. According to Fink (63), the interviews in the context of surveys tend to be semi-structured or structured (questionnaires). They can be conducted in-person or on the phone and a pre-established script is often strictly followed. As for self-administered instruments, they are given to individuals through the mail, via the Internet or on-site. Essentially these techniques are

concerned with measurement, quantification and instrument building, and with making sure that instruments are valid and reliable (68).

Sampling strategies

Sampling strategies take different forms in qualitative and quantitative studies. According to Streiner and Goering (61), in quantitative studies random sampling and predetermination of sample size constitute significant research strategies. They explain that subjects are chosen at random for different reasons: a) to meet the assumptions of statistical tests; b) to avoid bias; and c) to allow valid generalizations to the population from which the sample was drawn. The sample size is estimated early in the investigation so that statistical tests have enough power to detect significant differences between groups (that is, differences which are not due to chance).

In qualitative studies, however, the sample size is not determined a priori. Sampling is an ongoing process. Researchers continue to enroll new participants in the study until they are not learning anything new from them, that is when theoretical saturation (69) of the subject under investigation is achieved. It is worth noting that study participants are purposefully selected according to the specific information they hold (researchers can learn the most from them).

There are several sampling strategies in qualitative inquiries. Huberman and Miles (70) present a list of those strategies, some of which are:

a) maximum variation; b) homogeneous; c) critical case; d) confirming and disconfirming case; e) snowball; f) extreme or deviant cases; and g) convenience. Streiner and Goering (61) observe that, in contrast with the large sample sizes of quantitative studies, the final sample size of qualitative ones is often small (up to 20 participants), which allows in-depth, detailed analyses.

Data analysis and data quality

Quantitative data (numbers) analysis involves statistical techniques (descriptive and inferential statistics). The credibility of the information generated from quantitative data is based on the validity (e.g. criterion validity) and the reliability (e.g., alpha coefficient) of the research instruments, quite often expressed numerically. Generalization of results can be made for the sampled population.

Qualitative data (words) analysis can be conducted in different ways (e.g., content analysis, discourse analysis). However, a general data analysis process can be described regardless of the data collection method used. Qualitative raw data usually take the form of a text (e.g., verbatim of recorded interview, field notes), which is carefully examined by the investigator with the help of a coding system. The investigator is the main tool in this process of extracting from the text the researched information.

The credibility of the information produced depends on validity (confirmability - verification of findings with the informants) and reliability (consistency - intra/inter coder agreement) criteria. The generalization of findings does not follow the usual inference from a sample to the population from which the sample was drawn (70). The concept of transferability may be considered the qualitative version of generalization, despite some controversy among qualitative authors (60).

Triangulation is a qualitative research term meaning combination of different data collection methods, which can enhance the quality of gathered data. The central point of this strategy is to examine a single social phenomenon from more than one viewpoint (60). Illustrating triangulation with an example of triangulation, Yin (71) describes a case study conducted in a single school on the implementation of organization innovations. The study included a structured survey of a larger number of teachers, open-ended interviews with a smaller number of key persons, an observational protocol for measuring the time that students spent on various tasks, and a review of organizational documents. At the end of the description, Yin (71) highlights that all sources of evidence were reviewed and analyzed together, so that the case study's findings were based on the convergence of information from different sources.

Qualitative quantitative combined studies

Streiner and Goering (61) describe the conditions and the appropriate sequence for combining qualitative and quantitative studies. They view the respective methods as the appropriate tools for different and complementary tasks. When better understanding is needed in a new area, a qualitative study may be conducted before a quantitative one. These authors explain that the qualitative study will provide a broad understanding of a given context and may reveal research landmarks for the area under study, such as dependent and independent variables. This can facilitate the measurements of subsequent quantitative studies. A qualitative study followed by a quantitative one is also the sequence used for the development of a new instrument of measurement (as is the case in the research project described in this text). Another sequence is conducting a qualitative study after a quantitative one. This may be necessary when a quantitative study yields unclear results about a given study object. Then a qualitative study would provide investigators with a better understanding of the results.

Qualitative and quantitative studies can also be conducted at the same time when an investigation involves questions of how many, how much and how. The authors (61) illustrate this combination of methods with the example of an investigation on mental illness and pathways into homelessness. A classical epidemiological survey including a large representative sample of the population of homeless was conducted in order to assess the distribution of

mental illness and the factors that are associated with homelessness. In parallel, in-depth interviews were conducted with a smaller subset of subjects in the larger sample as well as with their family, providers, and friends. These interviews allowed a detailed understanding of the process by which individuals start using shelters or living in the street. Similar combinations have been used to address questions on drug addiction and AIDS (57).

A focus group session is a discussion in which a small number of people (6 to 10) talk about a topic proposed by a group facilitator (61). Focus group sessions have been used separately or in combination with other research techniques such as individual interviews, participant observation, surveys, and experiments (72).

Marshall (73) conducted a study which is a fine example of the combination of methods involving focus group sessions. In the study, semi-structured audio taped interviews (12 GPs and 12 specialists) were conducted along with four focus group sessions and a parallel survey to identify the main barriers to effective educational interaction between GPs and specialists and to suggest ways of overcoming these barriers.

The combination of qualitative and quantitative approaches is always made only at the methodological level. Even when combining methods, researchers still remain either on the qualitative or quantitative approach (e.g. different sampling strategies, different data analysis). The opposite epistemological and ontological assumptions of realistic and constructivist paradigms do not allow an end to the long lasting debate about dualism.

The qualitative-quantitative combination in this research project

As outlined above, the combination of qualitative and quantitative methods is possible, despite the dualism debate involving them. In the context of this research project, a qualitative study was conducted in advance of a quantitative one. Methodological assumptions (such as sampling strategies and data analyses) underlying qualitative and quantitative research were rigorously followed in both studies (as seen in the articles presented in the following section). The qualitative study provided a diverse corpus of information on collaboration involving psychiatrists who had hospital-based practices and GPs practicing in primary care settings. It allowed the identification of occasions of interaction between GPs and psychiatrists - patient referral and the training of residents in family medicine programs. It also allowed the identification of physicians' perceived roles and respective expectations in collaboration schemes, barriers that hold back the expansion of collaboration schemes, and suggestions on how to overcome the barriers in order to improve collaboration.

At this point in the research project, it was important to know how to use all this qualitative information to meet the overall objective of the project (identifying strategies, which may enhance collaboration between general practitioners and psychiatrists at the primary care level). According to this overall objective, it was then clear that the most important piece of information in the qualitative results was the one about suggestions to improve

collaboration. From this point on, the focus of the project was on the suggestions to improve collaboration. Given the number and variety of suggestions (involving physicians, patients and the organization and funding of services), a selection process was performed to identify suggestions which were indicated as a priority by physicians, and those that would be implemented easily and faster.

As a result, three groups of suggestions were identified to improve a) communication between GPs and psychiatrists, b) Continuing Medical Education for GPs in psychiatry, and c) GPs' access to consulting psychiatrists in primary care settings. These suggestions set the basis for designing a research instrument which measured their acceptability by GPs and psychiatrists practicing in the metropolitan area of Montreal. The instrument also confirmed the perception that emerged in the qualitative study that certain GPs and certain psychiatrists are more likely to engage in models of collaboration at the primary care level. A detailed description of these suggestions in the context of both studies is presented in the following articles.

FIRST ARTICLE

(QUALITATIVE STUDY)

TITLE

STRATEGIES OF COLLABORATION BETWEEN FAMILY PHYSICIANS AND PSYCHIATRISTS: A QUALITATIVE STUDY ON PHYSICIANS' VIEWS

AUTHORS

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ABSTRACT

Objective: To understand how to improve collaboration between psychiatrists and family physicians (FPs) in primary care settings.

Design: Qualitative study using ten in-depth interviews and a focus group session. A content analysis of data was performed.

Setting: Catchment area in eastern Montreal.

Participants: Five FPs and five psychiatrists.

Main findings: Three groups of strategies of collaboration were identified: a) communication; b) Continuing Medical Education (CME) for FPs and c) access to consulting psychiatrists. The first two groups of strategies may be implemented with the participation of both FPs and psychiatrists. However, the last one was not perceived by psychiatrists as viable due to time and remuneration restrictions in their current practice conditions.

Conclusion: Strategies of communication and of CME for FPs in psychiatry can be an option to improve collaboration between FPs and psychiatrists. However, strategies of access to consulting psychiatrists require significant alterations of established clinical routines and professional roles.

Key words: primary care, family physician, psychiatrist, collaboration, in-depth interviews; focus group.

BIOGRAPHICAL NOTE

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INTRODUCTION

Family physicians (FPs) are often the first professionals consulted in the help-seeking process of mentally ill individuals (1, 2). Globally they see the majority of patients with mental disorders (3, 4) and play important roles in the delivery of mental health care (5). However, FPs alone cannot provide mentally ill individuals with all the care they need (6). Collaboration with other professionals is widely recommended (6-9). Even an official liaison between the College of Family Physician and the Canadian Psychiatric Association was developed to promote collaborative mental health care, as described in *Canadian Family Physician* (October 1999 issue).

Models of collaboration between FPs and psychiatrists have been described in different countries, such as England (10, 11), Australia (12, 13) and the U.S. (14). The effectiveness of some models has already been confirmed in terms of helping FPs in the detection and management of mental disorders at the primary care level (15). In Canada, the McMaster approach, a pioneer model of collaboration, has been outlined in detail (16-20). Other experiences of collaboration in Ontario (21) and Quebec (22) were also described.

In addition to discussing these models, a few studies investigated dimensions of collaboration through practitioners' views. Williams and Wallace (23) surveyed both FPs and psychiatrists on how to improve written communication in a patient referral process. A questionnaire was sent to both

psychiatrists and FPs so that they could indicate items of fundamental importance in a FP's referral letter and in a psychiatrist's answer. Moreover, 100 referral letters were studied regarding the two sets of items considered important by both professionals. The authors found a good degree of correlation between what psychiatrists expected and what they received in referral letters from FPs. However, they found a small degree of correlation between the information FPs expected and received from psychiatrists and psychiatric services.

Bindman and colleagues (24) studied communication between FPs and psychiatric teams, as well as the FPs' views on their involvement in patient care. FPs reported that the information they received from psychiatric teams about the psychiatric care of their patients was limited. Most FPs perceived their role as providing physical care and repeating prescriptions of psychotropic drugs.

Studying FPs' working arrangements with mental health providers and their attitudes towards developing closer collaboration with psychiatrists in primary care settings, Barber and Williams (25) found that FPs had primary care links with psychiatrists, psychologists, psychiatric nurses and social workers. They also found that FPs held positive attitudes towards collaboration with psychiatrists in primary care settings.

Valenstein and colleagues (26) surveyed FPs' involvement in collaboration schemes with mental health professionals in community settings. The FPs indicated that they shared the treatment of approximately 30% of

their depressed patients with a mental health provider who was contacted only in about half of these cases. The authors identified co-location of FPs' and mental health professionals' practices (in the same building) as an important factor for collaboration.

Most of these studies (24-26) investigated only FPs' perceptions of collaboration with psychiatrists. Only one study (23) included the views of both FPs and psychiatrists with respect to improving one dimension of collaboration. However, no study investigated both FPs' and psychiatrists' views on how to improve several dimensions of collaboration. Considering these studies and the fact that qualitative methods comprise a powerful tool to answer questions in primary care (27, 28), a qualitative study was then designed with the overall purpose of collecting FPs' and psychiatrists' views on how to improve collaboration between them in primary care settings.

METHOD

The study was conducted in Montreal between 1998 and 1999. The sampled population was composed entirely of family physicians and psychiatrists who work in eastern Montreal. This district corresponds to the catchment area of a psychiatric hospital (Hôpital Louis H. Lafontaine) that serves a population of 356,077 (29), largely composed of native French speakers. The hospital is undergoing a major process of bed reduction over five years in order to place a greater emphasis on community care (30). For

this reason, strategies for collaboration between psychiatrists and FPs are urgently needed.

The recruitment of physicians for the study began with the identification of a key informant who was considered to be involved in collaborative care practices, who could be easily accessed, and who could effectively contribute to the study. To meet the basic criteria for inclusion in the study, one had to be a practicing physician (FP or psychiatrist) and to be able to provide us with information on different aspects of collaboration between FPs and psychiatrists. This physician was then contacted by one of the investigators and invited to participate. At this point the number of participants was not yet defined. It was determined as the interviewing period continued and when no further concepts were generated or new information was obtained, that is, when data saturation was achieved (31). As a result, a small motivated and articulate group of ten physicians was selected, including five FPs (three women, two men) and five psychiatrists (three men, two women). They all signed an informed consent form, which was submitted along with the study proposal for analysis and approval by the ethics and research committee of Hôpital Louis H. Lafontaine.

Ten individual in-depth audio-taped interviews were conducted by one of the authors (RJML) and a research assistant. About one week before each interview, the interviewer met the interviewee to provide an overview of the study and to deliver the questions for the interview (on current working arrangements, perceived roles, respective expectations, the barriers and

suggestions for improvement of collaboration*). This was done so that the participating physician could begin reflecting on the questions and preparing for the interview. FPs were asked a direct question about the suggestions for improvement of collaborative care: "What should be done to make possible the kind of collaboration that you would like to have with psychiatrists?" Psychiatrists were asked, "What should be done to make possible the kind of collaboration that you would like to have with FPs?"

The interviews lasted on average 90 minutes. The tapes were transcribed and a verbatim was produced for analysis. First, the interviewer read the verbatim of all the interviews. Second, he chose the two most comprehensive interviews in terms of diversity of information on the study themes: one from FPs, the other from psychiatrists. Then he analyzed the two interviews guided by a list of codes. At the same time, the research assistant conducted a similar analysis independently. This coding list was divided into five sections: 1) working arrangements, 2) roles, 3) expectations, 4) barriers, and 5) suggestions. Each code in the list was grouped in one of the sections and was extracted from the literature on collaboration, especially from the document *Shared Mental Health in Canada* (6), prepared by a joint working group of the Canadian Psychiatric Association and the College of Family Physicians of Canada, whose contents address the same points of the interviews. For example, the code "S-amelior/comuni" was used to label all

* In this article we are only presenting physicians' suggestions for improvement of collaborative care.

passages of verbatim where participants gave a suggestion to improve ("*améliorer*") communication.

After this preliminary assessment, the interviewer and the research assistant compared the results of the individual analyses and discussed the consistency of the coding system by checking codes and their respective quotations. Some codes were redefined, others deleted and new codes were added. The next step was to quantify the consistency of our coding system. Therefore, we coded and recoded separately random segments (over a hundred) of the verbatim of the two interviews. Then we calculated the code-recode reliability, as described in Huberman and Miles (32) for segments coded and recoded by the same person (intracoder agreement rate) and for the segments coded by each person individually (intercoder agreement rate). These showed 98% and 87% respectively. From here on, the verbatim of the other interviews was coded by the interviewer and the data reduction process was concluded. The computer software Atlas.ti, version 4.1 was used in the data analysis process. It facilitated the analysis by organizing codes, quotations, memos and conceptual networks in just one analytical unit (hermeneutic unit). Each interview had its own unit in the software, which allowed vertical (in the same interview) and horizontal (across interviews) analyses.

A summary of the results of the analysis was presented to each participant individually. This was an opportunity to have the participants' feedback on the analysis of the content of their interviews (confirmability).

Subsequently a focus group session was arranged to discuss the summary. It followed a discussion guide based on the summary of results and was conducted by a professional group facilitator. It was audio-taped and lasted 120 minutes. The tapes were transcribed, and the same data analysis procedure outlined above was applied to the verbatim of the focus group session. This final encounter with participants enriched the results of the interviews and highlighted psychiatrist's negative attitudes towards on-site collaboration with FPs in primary care settings.

FINDINGS

Participants

All five psychiatrists recruited conducted work at Hôpital Louis H. Lafontaine (outpatient clinic or psychiatric emergency) and were remunerated on a mixed system of sessional fees and fee-for-service. The sample of FPs was composed of two FPs from public CLSCs (centres for local health and social services), two in private practice, and one practicing in an emergency room of a general hospital. FPs were paid on a fee-for-service basis exclusively or combined with other forms of remuneration. All physicians in the study had at least ten years in practice. All were interviewed individually. Seven out of ten participating physicians attended the group discussion,

including four psychiatrists (two men, two women) and three FPs (two women, one man).

Emergent themes

As a result of the analysis of the participants' suggestions to improve collaboration, three main groups of strategies were identified: communication, CME for FPs in psychiatry, and access to a consulting psychiatrist. These strategies were drawn from verbatim extracts rather than from the author's opinion.

Strategies of communication

Improving written communication

Psychiatrists and FPs agreed that written communication is the easiest. The most common context for written communication is the referral process. In this situation, the referring FP should include in his or her consultation request relevant elements of the patient's clinical history (see Table I).

INSERT TABLE I

The psychiatrist should focus his or her answer to the FP's request on two issues: a) the diagnosis and b) the therapeutic plan, which should be

organized as an algorithm (point-by-point management plan). FP: *"...Send us a response telling us, 'The steps we suggest are this; if this doesn't work, try this; if that doesn't work, then try this, etc. etc'...."*

Improving phone communication

Phone communication should be used for a quick exchange of information between FPs and psychiatrists who already work together and whose patients are known by both physicians. For example, the consulting psychiatrist would call the referring FP to inform him or her of the results of an urgent patient assessment. Phone calls should be scheduled preferably for certain hours when both FPs and psychiatrists are available to talk. In a referral process, phone communication between these physicians should not be mediated by other professionals (e.g., nurses or social workers). FPs and psychiatrists should talk to each other directly. Participants also stated that prior personal contact between FPs and psychiatrists facilitates phone communication.

Strategies of CME in psychiatry for FPs

Improving educational linkages

Educational activities were described by participants as a very important tool for collaboration. Programs should be organized in accordance with input from FPs on their perceived needs to improve their work with

psychiatric patients. Psychiatrist: *"...I think the first step is to ask ourselves what do [FPs] need as training. What will really attract FPs [to this training]?..."*

The participants suggested that certain psychiatrists and certain FPs from the same catchment area take leadership in the organization of CME activities. They also suggested that CME activities take different formats, as seen in Table II.

INSERT TABLE II

FPs considered a psychiatrist's consultation report as their principal and regular source of continued medical education in the mental health field. Quick clinical exchanges on the phone with psychiatrists also contribute to increasing FPs' skills in mental health.

Strategies of access to a consulting psychiatrist

A visiting psychiatrist at primary care settings

The psychiatrists in the study expressed their willingness to collaborate with FPs. However, citing a lack of time and appropriate remuneration, none of them suggested regular visits to primary care settings. They also felt it would be difficult for FPs to meet them at psychiatric services. Psychiatrist: *"...I do not have the energy to tour medical clinics. I think it would be a waste of time... I am not even supposed to be paid if I am not on the premises of the hospital..."*

In contrast, all FPs described satisfactory experiences they had had with visiting psychiatrists at the primary care level. All these experiences took place within the context of a family medicine residency training, where a visiting psychiatrist discussed cases with residents and the practicing FPs were allowed to attend the case discussions. *FP: "...At the family medicine clinic where I work we have a consulting psychiatrist who visits once a week. ...This is ideal! I am fully satisfied..."*

FPs have suggested the following visiting model to facilitate their access to psychiatric consultation. One consulting psychiatrist would be formally linked to one or several FPs. Once a week the psychiatrist would visit primary care services, such as CLSC and family practice units. He or she would discuss complicated cases with FPs, help them with worker's disability issues and, when required, perform direct patient assessments.

DISCUSSION

Collaboration between FPs and psychiatrists seems to be more complex than reported recommendations imply (6, 8, 9). Blount (33) explains that collaborative care between mental health providers and primary care physicians lies on a continuum which ranges from occasional courtesy communication at one extreme to on-site collaboration and team work at the other. Providers working in close collaboration need to share a common system of values, perceptions, language and thinking about their joint work to provide patient care.

Based on their satisfactory experience in the context of a family medicine residency program, FPs proposed a visiting model to facilitate their access to psychiatric consultation. Similar models of on-site collaboration may be successful in a specific context (16-20) and represent a singular way of providing care, which requires significant alteration of established clinical routines and professional roles. Thus it seems to be quite difficult to apply these models with all practice contexts involving FPs and psychiatrists.

As outlined in American national surveys (34, 35), psychiatrists dedicate most of their work time to direct patient care. They also allocate time to administration, teaching, and research. Therefore, it is understandable that it would be difficult for them to participate in extra activities (e.g. collaboration with FPs). Moreover, they need to possess specific skills (beyond the traditional theoretical framework of hospital psychiatry) in order to serve as consultants for FPs in primary care settings (19, 36, 37).

By the same token, FPs work under very tight schedules in primary care settings (38, 39) and deal with different medical scenarios which vary from childhood asthma and immunization to cancer screening and congestive heart failure in the elderly. In this context, detecting and treating psychiatric disorders may not be a priority (40). In addition, the fee-for-service system of remuneration motivates the delivery of medical services in short intervals of time, eight to twelve minutes (41), which is incompatible with the length required for psychiatric appointments, thirty to ninety minutes (41).

Accordingly, it would be reasonable to take gradual steps in the organization of closer working arrangements between FPs and psychiatrists. First, communication should be improved between FPs' offices and psychiatrists' outpatient clinics, which constitute the cornerstone of the current psychiatric network of services and are the main link between the network and primary care settings (42). Then attention should be brought to non-traditional sources of CME for FPs in psychiatry, such as the psychiatrist's consultation report, and to the organization of CME activities based on practitioners' perceived needs. Physician acceptance of a practice-based approach for the organization of CME activities has also been reported elsewhere (43, 44, 16, 19).

On-site collaboration schemes developed as a consequence of the initiative of individual FPs and psychiatrists (10) should receive appropriate administrative and financial support. In this matter, it should be highlighted that female FPs and young FPs (25), young psychiatrists (10, 45), as well as FPs and psychiatrists practicing in the same building (26) may engage more promptly in closer working arrangements.

FUTURE DIRECTIONS FOR RESEARCH STEMMING FROM THIS STUDY

Surveys could be designed to collect the opinions of both FPs and psychiatrists with respect to the strategies of communication, CME for FPs in psychiatry, and access to consulting psychiatrists. Demographic and practice

characteristics of physicians more likely to engage in schemes of collaborative care could also be identified. Furthermore, exploratory studies on strategies of collaboration should be conducted using qualitative methods. In these studies, samples should include FPs both from urban and rural areas and psychiatrists in private practices.

LIMITATIONS OF THE STUDY

We identified the following limitations of our study. First, despite the diversity of the FP population (46), FPs participating in this study were quite homogeneous, considering their knowledge and positive attitudes in relation to the detection and management of mental disorders in their patients. Therefore, strategies presented here may not be fully accepted by FPs with different characteristics. Second, the physicians' perceptions were collected through individual interviews and a focus group session. However, no data collection method of direct observation, such as participant observation, was used to validate the collected information.

CONCLUSION

The improvement of collaboration between FPs and psychiatrists can be achieved through groups of strategies. Strategies involving communication and organization of CME for FPs in psychiatry may elicit more positive attitudes among physicians than those involving on-site collaboration in primary care settings.

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TABLES

Table I: Elements of FP's consultation request

- Diagnostic impression
- Therapeutic approaches attempted so far (medication, dosage, type of psychotherapy, length of the intervention, patient response)
- Physical health problems
- Previous psychiatric contacts
- Aim of the consultation

Table II: Formats of CME activities

- Regular meetings to discuss cases and review relevant educational materials;
- Balint groups
- Lunch or dinner lectures
- Workshops
- Half-day medication updates
- Formal symposia and conferences

SECOND ARTICLE

(QUANTITATIVE STUDY)

TITLE

STRATEGIES OF COLLABORATION BETWEEN GENERAL PRACTITIONERS AND PSYCHIATRISTS: A SURVEY OF PRACTITIONERS' OPINIONS AND CHARACTERISTICS

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ABSTRACT

The description of models of collaboration and the key principles underlying them provide important information for designing services. However, in order to apply this broad corpus of information to clinical services and policymaking, we need to know which key principles (or strategies) of collaboration are the most accepted by local physicians. In this context, a survey was designed with two objectives: 1) to collect the opinions of practicing GPs and psychiatrists in Montreal with respect to strategies for improving collaboration between these two groups of physicians, and 2) to identify demographic and practice characteristics of those physicians associated with the acceptance of such strategies. A questionnaire was specifically designed to elicit physicians' opinions about strategies involving communication, Continuing Medical Education (CME) for GPs in psychiatry and access to consulting psychiatrists, as well as to identify the profiles of the respondent physicians. It was mailed to 203 GPs and 203 psychiatrists randomly selected. The response rate was 86% for GPs and 87% for psychiatrists. Physicians expressed favorable opinions about most strategies involving 1) the improvement of communication and 2) the organization of CME activities concerning GPs' practices in the field of psychiatry. However, they did not indicate acceptance of the strategies involving on-site collaboration between GPs and psychiatrists. Physician gender, age, place of practice, type of practice (such as seeing patients with or without appointments), and responsibility for administrative duties were significantly associated with the degree of acceptance of the proposed strategies.

KEY WORDS: Collaboration; general practitioner; psychiatrist; primary care; questionnire designing; survey.

INTRODUCTION

A worldwide tendency has developed for health services to be designed with a focus on primary care (1, 2, 3). In the field of mental health, studies have shown that the prevalence of mental disorders in the community ranges from 13 to 29.5% (4-8), and that only a small portion (about 13%) of individuals with a mental disorder seek professional help (5, 8, 9, 10). Those who do, seek it at the primary care level (5, 11). General practitioners (GPs) are often the first professionals consulted in the help-seeking process of these individuals (9, 12). Globally they see the majority of patients with mental disorders (13, 14) and play an important role in the delivery of mental health care (15). However, GPs alone cannot provide mentally ill individuals with all the care they need (16). Collaboration with other professionals is widely recommended, especially with psychiatrists (16-19).

Models of collaboration involving these physicians have been extensively outlined in the literature (20-23), some of which were implemented in Ontario (24-29) and in Quebec (30). Key principles underlying models of collaboration have been identified (16, 31, 32). However, only a few studies have considered the views of practitioners concerning collaboration.

Strathdee (33) studied the extent and the nature of collaboration between GPs and psychiatrists. She identified three main models of collaboration (shifted outpatient, consultation, and liaison-attachment), which were developed as a consequence of the initiative of certain GPs and

psychiatrists. Physicians involved in closer working arrangements (liaison-attachment model) were in the minority.

Williams and Wallace (34) surveyed both GPs and psychiatrists on how to improve written communication in a patient referral process. The authors found a good degree of correlation between what psychiatrists expected and what they received in the referral letter. However, the GPs' degree of correlation was small and their needs from psychiatrists and psychiatric services were not being met.

Bindman and colleagues (35) studied communication between a group of GPs involved in the care of severe mentally ill patients and psychiatric teams, as well as the GPs' views on their involvement in patient care. GPs and patients were interviewed. GPs reported that the information they received from psychiatric teams about the psychiatric care of their patients was limited. Most GPs perceived their role as providing physical care and repeating prescriptions of psychotropic drugs. More than half the patients confirmed the GPs' perceived role.

Studying GPs' working arrangements with mental health providers and their attitudes towards developing closer collaboration with psychiatrists in primary care settings, Barber and Williams (36) found that GPs had primary care links with psychiatrists, psychologists, psychiatric nurses and social workers. They also found that GPs held positive attitudes towards collaboration with psychiatrists in primary care settings. Despite the GPs'

openness to collaboration models, the authors suggested caution in the interpretation of these results due to the small study sample.

Valenstein and colleagues (37) surveyed GPs' involvement in collaboration schemes with mental health professionals in community settings. The GPs indicated that they shared the treatment of approximately 30% of their depressed patients with a mental health provider who was contacted only in about half of these cases. The authors identified co-location of GPs' and mental health professionals' practices (in the same building) as an important factor for collaboration.

Von Guten and Villoz (38) conducted interviews with a group of physicians involved in a consultation liaison service offered in a general hospital. The physicians reported a positive impact from the consultation in the management of their own practices and in patient outcomes. They suggested that the referring physician should be better integrated in the consultation process when a referred patient is hospitalized. They also suggested that referring physicians should often participate in the evaluation of the quality of a consultation liaison service.

Most of these studies (35-38) investigated only GPs perceptions of collaboration with psychiatrists, and one (38) did not focus on primary care settings. Only two studies included the views of both GPs and psychiatrists. However, in one of them (33) only physicians involved in collaboration were recruited and in the other (34) only one dimension of collaboration (written communication) was investigated. No study surveyed both types of physicians'

views about specific strategies of collaboration and no study involved random samples of physicians.

Therefore, a survey was designed with two objectives. The first was to collect the opinions of both GPs and psychiatrists practicing in Montreal with respect to strategies for improving collaboration between them at three levels: communication, Continuing Medical Education (CME) for GPs in psychiatry, and on-site collaboration in primary care settings. The second objective was to identify demographic and practice characteristics of physicians associated with the acceptance of such strategies.

METHOD

Questionnaire development

The development of our questionnaire evolved as follows. First, we reviewed the literature on collaboration between GPs and psychiatrists. Second, we conducted ten in-depth interviews and one focus group session in a purposefully selected sample of five GPs and five psychiatrists. Third, we designed the first drafts of the questionnaire. The sources of the items were the following: a) the analyzed verbatim of the interviews and focus group session, b) the document, "Shared Mental Health Care in Canada" (16), and c) other questionnaires (37, 39).

The items (53 in total) were grouped into three sections of strategies: Section A: communication; Section B: Continuing Medical Education (CME);

and Section C: access to consulting psychiatrists. Each item was the same for both psychiatrists and GPs, and was measured through a 5 point Likert Scale (1 = strongly disagree to 5 = strongly agree).

Another section (Section D) was also developed to collect demographic and practice related data. It was specific for each group and included the following variables: 1) gender; 2) age; 3) year of graduation; 4) years in practice; 5) place of practice - hospital or community settings, including private practice, CLSC (community health center), psychiatric outpatient clinic, rehabilitation center and emergency room; 6) type of practice I (solo or group practice); 7) type of practice II (practice with appointment, without appointment, or both); 8) form of remuneration (fee-for-service, fee-for-service combined with another form of remuneration, sessional fees, salary, hourly fees); 9) teaching (yes or no); 10) research (yes or no); 11) administration (yes or no); 12) hours of work per week; 13) GPs only - residency training in family medicine (yes or no); 14) GPs only - percentage of patients with mental health problems followed by GPs; and 15) psychiatrists only - psychiatric clientele (adult, children/adolescent, elderly).

Then, when a preliminary version of the questionnaire was ready, it was submitted to the analysis of a group of professionals (three GPs, three psychiatrists and one psychologist) who are members of the Committee on Support of Psychiatric Shared Care from Régie régionale de Montréal-Centre. The questionnaire was also presented individually to different clinicians, researchers and health planners. Although the basic structure (Sections A, B,

C, and D) of the questionnaire was the same, the suggestions of these advisors helped to improve the layout of the questionnaire and the wording of the items (some items were rewritten, others deleted and new items were added).

Subsequently, the questionnaire was subjected to a pretest which was conducted with a small group of physicians (7 GPs and 6 psychiatrists). Following the pretest, the questionnaire and the survey proposal were submitted to the analysis and approval of the ethics and research committee of Hôpital Louis H. Lafontaine in Montreal, affiliated with Université de Montréal.

Sampling

Those eligible for participation in the survey were GPs and psychiatrists practicing medicine in Montreal whose preferred language of correspondence with the Quebec medical association (Le Collège des médecins du Québec) is French. It is important to note that the vast majority of physicians (75% of GPs and 74% of psychiatrists) working in Montreal use French as their preferred language. Furthermore, this survey was designed in a French-speaking environment (Centre de Recherche Fernand-Seguin). Physicians connected with the development of the questionnaire (GPs and psychiatrists who participated in the interviews, in the focus group session, in the pretest of the questionnaire and in the questionnaire design) were excluded. The estimated

sample size for both GPs and psychiatrists was 125, with type I error at .05 and power of .80 for two-sided tests. This estimation was based on the results of the pretest of the questionnaire. Expecting a dropout rate of 30%, 203 GPs (9% of all eligible GPs) and 203 psychiatrists (36% of all eligible psychiatrists) were randomly selected from an electronic list provided by Le Collège des médecins du Québec.

Research design

A mail survey was conducted in the fall of 2000 and was based on Dillman's total design method (40). Initially 406 envelopes including a cover letter, a copy of the questionnaire and a stamped return envelope were sent to 203 GPs and 203 psychiatrists. Each questionnaire mailed was assigned a number so that we could be aware of its return. Subsequent to the mailing, three follow-up reminders were sent to non-respondents and one phone contact was made.

Data analysis

The process of data analysis was conducted by using computer software SPSS for windows, version 9.0 (41). The primary analysis had two stages. First, the response rate was determined and significant group differences between the respondents and the non-respondents were

investigated. Second, a profile of respondent physicians was made according to demographic and practice variables. The secondary analysis included two stages as well. First, the dimensions underlying the strategies of collaboration were identified through exploratory factor analysis. Second, significant differences between GPs and psychiatrists and the identified dimensions were assessed using covariance analyses on (A*B) factorial design. This statistical method minimizes biases related to age and the other characteristics of physicians. Weighted-mean analyses were conducted using Gram-Schmidt orthogonalization (42) of the comparisons. The critical level of significance was set at 5%.

RESULTS

Response rate

Out of 406 mailed questionnaires, 306 questionnaires (142 GPs and 164 psychiatrists) were received. A total of 53 physicians (38 GPs and 15 psychiatrists) were deemed ineligible for survey participation for the following reasons: respondent retired; respondent exclusively in administration or research; respondent on medical leave; respondent (GP) practicing as specialist; respondent moved; respondent on sabbatical; and respondent (psychiatrist) exclusively forensic or insurance consultant. Excluding these ineligible physicians, a response rate of 86% (142/165) for GPs and 87%

(164/188) for psychiatrists was achieved. Twenty three questionnaires of the 306 were not fully completed. To assure the quality of answers, they were not considered in the analysis process. The analyses were therefore conducted on 283 questionnaires (131 GPs and 152 psychiatrists). No significant differences were found between the respondents and the non-respondents, regarding sex, medical specialty (GP or psychiatrist) and year of graduation in medicine. Information on these variables was available for both respondents and non-respondents.

INSERT TABLE I

Sample demographics and practice characteristics

Demographic and practice characteristics of the sample are summarized in Table I. The male/female ratio did not differ significantly between GPs and psychiatrists. Similarly, the mean age, although higher for psychiatrists, did not differ significantly. The proportion of physicians older than 49 years was similar between the two groups of physicians. GPs differed from psychiatrists in terms of place of work, type of practice, and form of remuneration. Teaching, administration and research activities were more frequent for psychiatrists. No significant difference was found between the two groups in terms of hours of work per week. Over half of the psychiatrists (67%) see only adult patients. GPs estimate that about 20% of the patients they see

have mental health problems. Most (73%) GPs in the study did not complete a residency in family medicine (probably due to the fact that the residency in family medicine became a requirement for practice after most physicians in the sample had graduated).

INSERT TABLE II

Dimensions of the questionnaire

The exploratory factor analysis by principal axis factoring (varimax rotation) enabled the identification of five dimensions (or factors) underlying the strategies of collaboration outlined on sections A, B and C of the questionnaire. The scree plot test showed five well distinct factors with the following eigen values: F1=6.0; F2=3.4; F3=2.1; F4=1.9; F5=1.6. These factors explain 50.4% of the total variance. As seen in Table II, each item loads on just one factor and each factor loading is higher than .40. Moreover, all factors show satisfactory alpha coefficients (43), all of them higher than .70. Similar results were found for the factor analyses conducted separately for GPs and for psychiatrists. In brief, all factors identified represent basically intertwined groups of strategies: a) strategies of communication: F3 and F4 ($r = .237$; $p < .01$); b) strategies of CME: F1 and F5 ($r = .277$; $p < .01$); and c) strategies of access to consulting psychiatrists: F2.

As shown in Table II, strategies of communication are represented in two dimensions: F3 and F4. F3 introduces the elements that GPs should include in their consultation request to a psychiatrist and F4 describes the direct information exchange between GPs and psychiatrists which should take place in the context of a patient referral. Strategies of CME are also represented in two dimensions: F1 and F5. F1 clusters mostly items of the questionnaire which describe the organization of CME activities (such as workshops, conferences and briefings) for GPs in psychiatry. As for F5, it points out the importance of the psychiatrist's consultation report as a source of CME for GPs in psychiatry. Finally, the strategies of access to consulting psychiatrists are represented in only one dimension (F2). It includes mainly items describing a consulting psychiatrist's tasks which may facilitate GPs' access to psychiatric services in primary care settings.

INSERT TABLE III

Acceptance of the strategies of collaboration for GPs and for psychiatrists

A mean score was calculated for GPs and for psychiatrists in each dimension of the questionnaire. Scores higher than four represent agreement with the proposed strategies, whereas scores between three and four represent only a tendency to express agreement. As can be seen in Table III,

the mean scores for F3, F4 and F1 were above 4, and between 3 and 4 for F5 and F2. GPs and psychiatrists express clear agreement with most strategies, except those related to access to consulting psychiatrists. Psychiatrists accept more than GPs themselves the elements suggested to be included in the GP consultation request. GPs fully accept the psychiatrist's consultation report as an important source of CME, whereas psychiatrists do not fully express their agreement. GPs and especially psychiatrists do not express agreement with the strategies of access to consulting psychiatrists.

INSERT TABLE IV

Acceptance of the strategies of collaboration according to physician demographics and practice characteristics

Significant associations were identified between the strategies of collaboration and the following variables: age, gender, place of work, administration and type of practice.

Strategies of communication

As seen in Table IV, the GP's consultation request [F3] was accepted at a higher level by the psychiatrists independent of their age category ($F_{1, 273}$ = 18.65), although the physicians younger than 50 years old agreed to a higher

level ($F_{1, 273} = 4.13$). Female GPs and female psychiatrists scored higher than men ($F'_{1, 272} = 5.92$). No significant differences in relation to the strategies of direct information exchange [F4] were found for GPs or psychiatrists across the demographic and practice characteristics.

INSERT TABLE V

Strategies of CME for GPs in psychiatry

As seen in Table V, physicians 50 or more years old scored higher their agreement with the strategies of organization of CME activities [F1] ($F_{1, 273} = 4.47$). Considering these strategies, female psychiatrists expressed a lower level of agreement than female GPs ($F'_{1, 271} = 9.57$) and male psychiatrists ($F'_{1, 271} = 7.22$). This obvious difference led to a significant gender by specialty interaction ($F'_{1, 271} = 8.38$, $p < .01$). A physician's place of work also had an effect on the scores. In community settings, psychiatrists scored lower than GPs ($F'_{1, 272} = 5.89$). Conversely, at hospitals psychiatrists scored higher than GPs ($F'_{1, 272} = 4.93$). This inversion of scores led to a significant interaction ($F'_{1, 272} = 9.97$). Neither teaching nor administration yields score differences between the two groups of physicians. However, GPs practicing with appointments scored significantly higher than both psychiatrists with appointments ($F'_{1, 265} = 8.14$) and GPs without appointments ($F'_{1, 265} = 7.94$). This difference led to a significant interaction ($F'_{1, 265} = 4.09$; $p<.05$).

As shown in Table V, physicians 50 or more years old ($F_{1, 273} = 5.01$) scored higher in the psychiatrist's consultation report as CME [F5]. No gender effect was found in this strategy. No influence of place of work, type of practice or teaching was observed. A significant interaction ($F'_{1, 272} = 4.80$) involving administrative responsibilities was observed. Psychiatrists not involved in administration scored lower than GPs ($F'_{1, 272} = 21.16$).

Strategies of access to consulting psychiatrists

In the strategies of access to consulting psychiatrists [F2] significant interactions were observed between the two groups of physicians and age categories ($F_{1, 273} = 4.31$; $p<.05$), gender ($F'_{1, 272} = 7.77$; $p<.01$) and place of work ($F'_{1, 269} = 8.50$; $p<.01$). Younger psychiatrists expressed the lowest score of all physicians and differed from older psychiatrists ($F_{1, 273} = 7.13$) and younger GPs ($F_{1, 273} = 49.83$). In addition, older GPs scored higher than older psychiatrists ($F_{1, 273} = 15.86$). Female GPs scored higher than male GPs ($F'_{1, 272} = 6.65$). Both female GPs ($F'_{1, 272} = 51.43$) and male GPs ($F'_{1, 272} = 18.88$) scored higher than psychiatrists. No gender difference was observed among psychiatrists. At place of work the very high score of GPs in the community differed from both GPs at hospitals ($F'_{1, 269} = 5.40$) and psychiatrists in community settings ($F'_{1, 269} = 62.67$). Teaching, administration and type of practice did not interfere with this group of strategies.

DISCUSSION

Co-location (in the same building) of the practices of primary care physicians and mental health professionals has been identified as a strong predictor of collaboration (37). The benefits (mostly for GPs' practices) of on-site collaboration between primary care physicians and mental health professionals have been reported (23, 44, 45). However, GPs and especially psychiatrists in this survey did not express agreement with psychiatrists moving their consultation practices to primary care settings or even visiting such settings periodically.

Initially it should be pointed out that on-site collaboration is an intense and complex form of collaborative care. Blount (46) explains that collaborative care between mental health providers and primary care physicians lies on a continuum, which ranges from occasional courtesy communication at one extreme to on-site collaboration and team work at the other. Providers working in close collaboration need to share a common system of values, perceptions, language and thinking about their joint work to provide patient care. Can GPs and psychiatrists integrate their quite distinct clinical backgrounds to work as "natural partners," as has been suggested (16)?

The busy clinical routines of GPs and psychiatrists should be considered. GPs work under very tight schedules in primary care settings (47, 48) and deal with different medical scenarios which vary from childhood asthma and immunization to cancer screening and congestive heart failure in

the elderly. In this context, detecting and treating psychiatric disorders may not be a priority (49). In addition, the fee-for-service system of remuneration motivates the delivery of medical services in short intervals of time, eight to twelve minutes (50), which is incompatible with the length required for psychiatric appointments, thirty to ninety minutes (50).

By the same token, as outlined in American national surveys (51, 52), psychiatrists dedicate most of their work time to direct patient care. They also allocate their time to administration, teaching, and research. Therefore, it is understandable that it would be difficult for them to participate in extra activities (e.g. collaboration with GPs). Moreover, they need to possess specific skills (beyond the traditional theoretical framework of hospital psychiatry) in order to serve as consultants for GPs in primary care settings (27, 53, 54). In summary, on-site collaboration between psychiatrists and GPs represents an organizational change which requires significant alteration of established clinical routines and professional roles.

Accordingly, it would be reasonable to take gradual steps in the organization of closer working arrangements between GPs and psychiatrists. First, communication should be improved between GPs' offices and psychiatrists' outpatient clinics, which constitute the cornerstone of the current psychiatric network of services and are the main link between the network and primary care settings (55). Personal contacts should be built between psychiatrists and GPs at this point with the support of their respective organizations of work. Then attention should be brought to non-traditional

sources of CME for GPs in psychiatry, such as the psychiatrist's consultation report, and to the organization of CME activities based on practitioners' perceived needs. Physician acceptance of a practice-based approach for the organization of CME activities has also been reported elsewhere (56, 57, 24, 27). The organization of these activities would require the leadership of some GPs and psychiatrists.

On-site collaboration schemes developed as a consequence of the initiative of individual GPs and psychiatrists (33) should receive the appropriate administrative and financial support. In this matter, it should be highlighted that female GPs and young GPs (36), young psychiatrists (33, 39), as well as GPs and psychiatrists practicing in the same building (37), are more likely to participate in closer working arrangements with mental health providers.

LIMITATIONS OF THE STUDY

Our study has the following limitations. First, the questionnaire used in this survey was a new instrument with no psychometric characteristics (such as reliability and validity) which had been previously established. The validation process of our instrument has just begun and should be continued by other researchers, in order to reinforce the validity and reliability of our results. Second, no pilot study was conducted, and therefore a preliminary analysis of the items of the questionnaire was not done to increase the content

validity of our instrument. A pilot study could have allowed a more accurate sample size estimation. Third, English speaking physicians, a minority in Montreal, did not participate in the survey therefore limiting the extent of generalization of our results.

CONCLUSION

The literature on models of collaboration and the key principles underlying them provides important information for designing services. However, in order to apply this broad corpus of information to local clinical services and policymaking, we need to know what key principles (or strategies) of collaboration are the most accepted by local physicians. According to physicians practicing in Montreal, strategies of collaboration involving 1) the improvement of communication and 2) the organization of CME activities concerning GPs' practices in the field of psychiatry are more acceptable than those involving on-site collaboration between GPs and psychiatrists. Physician gender, age, place of practice, type of practice (such as seeing patients with or without appointments), and responsibility for administrative duties were significantly associated with the degree of acceptance of the proposed strategies.

IMPLICATIONS

- The opinion of local practitioners is now available to be considered in the design of health services.
- Strategies considered to be the most accepted in the implementation of collaboration schemes have been identified.
- Physician demographic and practice characteristics associated with the acceptance of the strategies of collaboration can be considered in the identification of physicians who may engage more promptly in models of collaboration.

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Table I: Physician demographics and practice characteristics

	GPs (N=131)	Psychiatrists (N=152)	Statistical significance
Gender (male / female ratio)	72 / 59	96 / 56	$\chi^2_1 = 1.96$; $p = .162$
Average age (mean of years ± S.E.M.[a])	48.9 ± 1.0	51.4 ± .98	$t_{276} = -1.81$; $p = .071$
Age distribution (<50 / ≥50 years ratio)	70 / 57	70 / 80	$\chi^2_1 = 1.96$; $p = .161$
Place of work (hospital/community settings ratio)	25 / 106	88 / 63	$\chi^2_1 = 16.75$; $p < .000$
Type of practice I (solo/group practice ratio)	34 / 92	63 / 86	$\chi^2_1 = 7.00$; $p < .008$
Type of practice II (with appointment/without appointment/ both ratio)	36 / 20 / 70	87 / 8 / 54	$\chi^2_2 = 26.62$; $p < .000$
Remuneration (fee-for-service/ fee-for-service combined/ sessional fees/ salary/ hourly fees ratio)	81 / 14 / 7 /18 / 11	15 / 50 / 76 / 4 / 4	$\chi^2_4 = 134.56$; $p < .000$
Teaching (yes/no ratio)	23 / 108	96 / 56	$\chi^2_1 = 60.04$; $p < .000$
Administration (yes/no ratio)	14 / 113	28 / 122	$\chi^2_1 = 3.30$; $p = .068$
Research (yes/no ratio)	7 / 124	43 / 109	$\chi^2_1 = 25.47$; $p < .000$
Average hours of work (mean of hours ± S.E.M.[a])	42 ± 1.0	43 ± .91	$t_{270} = -.586$; $p = .558$

[a] *S.E.M. (standard error of the mean)*

Table II: Factor structure of the strategies of collaboration between GPs and psychiatrists

FACTORS (N = 283)	F1	F2	F3	F4	F5
Items per factor	8	8	7	5	2
Alpha coefficient	.82	.80	.79	.75	.82
F1 (Organization of CME activities)	**Factor loading**				
CME: could be organized by both GPs and psychiatrists	.516				
Workshops: could include case discussions	.729				
Workshops: could offer pertinent handouts	.608				
Workshops: could be in the form of a joint presentation	.537				
Conferences: could allow free exchanges between GPs and the presenting psychiatrist	.660				
Half-day briefings: could take place at appointed intervals	.473				
Workshop: important source of CME for GPs	.598				
Conference: important source of CME for GPs	.404				
F2 (Access to consulting psychiatrists)					
Consulting psychiatrists: preestablished hours to take GPs' calls		.437			
Consulting psychiatrists: catchment area defined on the basis of GPs' office addresses		.425			
Consulting psychiatrists: in CLSC		.618			
Consulting psychiatrists: in general practice clinics		.658			
Consulting psychiatrists: available for joint clinical evaluations with GPs, if necessary		.660			
Consulting psychiatrists: available for patient home evaluations, if necessary		.587			
Consulting psychiatrists: specific consultation service for patients on work leave		.519			
Consulting psychiatrists: carry out educational activities at the GP's office		.607			
F3 (Elements of a GP's consultation request)					
Previous treatment trials			.545		
Assessment of the referred patient's suicide or homicide risk, if applicable			.477		
Pertinent medical antecedents of the referred patient			.723		
Pertinent psychiatric antecedents of the referred patient, if applicable			.726		
Indication of whether or not the referral involves a case of patient work leave			.526		
Referred patient's contact with non medical mental health professionals			.704		
Referring GP's expectations and needs concerning the psychiatric evaluation			.456		
F4 (Direct information exchange between GPs and psychiatrists)					
Phone calls: urgent cases				.528	
Phone calls: referring GPs should be allowed to talk directly to the psychiatrist				.512	
Phone calls: effective and easy way of information exchange				.663	
On-site information exchange: important source of CME for GPs				.476	
Information exchange on the phone: important source of CME for GPs				.719	
F5 (Psychiatrist's consultation report as CME)					
Psychiatrist's consultation report: could be an excellent source of CME for GPs					.727
Psychiatrist's consultation report: important source of CME for GPs					.833

Extraction method: Principal Axis Factoring
Rotation method: Varimax with Kaiser Normalization (rotation converged in 7 iterations)

Table III: Acceptance of the strategies of collaboration by physician specialty

Strategies of collaboration	Means and S.E.M.[a]		Statistical Significance
	GPs (N=131)	Psychiatrists (N=152)	
F1 Organization of CME activities	4.30 ± 0.04	4.27 ± 0.03	n.s.
F2 Access to consulting psychiatrists	3.69 ± 0.05	3.07 ± 0.05	t_{281} =8.291***
F3 GP's consultation request	4.17 ± 0.05	4.45 ± 0.03	t_{281} =-4.490***
F4 Direct information exchange	4.05 ± 0.05	4.08 ± 0.05	n.s.
F5 Psychiatrist's consultation report as CME	4.19 ± 0.08	3.79 ± 0.07	t_{281} =3.822***

[a] *S.E.M. (standard error of the mean)*
*** $p < .001$

Table IV: Acceptance of the strategies of communication by physician demographics and practice characteristics

VARIABLE	CATEGORIES	F3 GP's consultation request		F4 Direct information exchange	
		GP	Psychiatrist	GP	Psychiatrist
AGE (a)	≥ 50 years	4.05 ± .085 ▲	4.46 ± .056 ***	4.05 ± .095	4.12 ± .072
	< 50 years	4.29 ± .079 ***	4.54 ± .078 ▲	4.10 ± .082	4.01 ± .090
GENDER (b)	Female	4.31±.085 ▲	4.59 ± .081 ***	4.09 ± .098	4.01 ± .095
	Male	4.07 ± .078 ***	4.45 ± .057 ▲	4.08 ± .080	4.10 ± .071
PLACE OF WORK (b)	Community	4.20 ± .060	4.53 ± .058 ***	4.12 ± .070	4.04 ± .078
	Hospital	4.04 ± .168 ***	4.47 ± .078	3.94 ± .135	4.12 ± .081
ADMINISTRATION (b)	No	4.20 ± .060	4.51 ± .052 ***	4.07 ± .066	4.04 ± .065
	Yes	3.99 ± .211 ***	4.47 ± .111	4.15 ± .176	4.21 ± .105
TYPE OF PRACTICE (b)	Without app. and both	4.17 ± .074	4.41 ± .086***	4.05 ± .078	4.21 ± .078
	With app.	4.20 ± .095***	4.56 ± .052	4.14 ± .114	3.96 ± .079

(a) mean score ± standard error of the mean; (b) age-adjusted mean score ± standard error of the mean;
**** p < .001 for the differences between GPs and psychiatrists;*
▲ p < .05 for the differences between the categories of demographic and practice characteristics.

Table V: Acceptance of the strategies of CME and access to consulting psychiatrists by physician demographics and practice characteristics

VARIABLE	CATEGORIES	F1 Organization of CME activities		F5 Psychiatrist's consultation report as CME		F2 Access to consulting psychiatrists	
		GP	Psychiatrist	GP	Psychiatrist	GP	Psychiatrist
AGE (a)	≥ 50 years	4.51 ± .071 ▲	4.33 ± .053	4.42 ± .100 ▲	4.08 ± .087 ***	3.75 ± .088	3.28 ± .083 ***
	< 50 years	4.27 ± .064	4.29 ± .071 ▲	4.27 ± .113 ***	3.77 ± .114 ▲	3.80 ± .083 ***	2.97 ± .079 ▲▲
GENDER (b)	Female	4.47 ± .072**	4.16 ± .074▲▲	4.39 ± .118	3.78 ± .118 ***	3.97 ± .092 ▲	3.02 ± .085 ***
	Male	4.34 ± .063	4.40 ± .052	4.31 ± .102 ***	4.01 ± .087	3.65 ± .077 ***	3.18 ± .076
PLACE OF WORK (b)	Community	4.46 ± .053 ▲▲	4.27 ± .057 *	4.33 ± .088	3.92 ± .089 ***	3.84 ± .061	3.06 ± .073 ***
	Hospital	4.08 ± .093 *	4.36 ± .068	4.44 ± .154 ***	3.92 ± .113	3.48 ± .170 ▲	3.26 ± .089
ADMINISTRATION (b)	No	4.42 ± .049	4.31 ± .048	4.40 ± .079	3.88 ± .078 ***	3.79 ± .063	3.10 ± .064 ***
	Yes	4.18 ± .175	4.30 ± .088	3.95 ± .267	4.10 ± .162	3.71 ± .196 ***	3.21 ± .133
TYPE OF PRACTICE (b)	With/without and Without	4.32 ± .057▲▲	4.29 ± .072	4.34 ± .089	4.03 ± .107***	3.76 ± .073	3.18 ± .087***
	With	4.61 ± .079	4.31 ± .055**	4.41 ± .149***	3.85 ± ..092	3.81 ± .111***	3.08 ± .077

(a) mean score ± standard error of the mean; (b) age-adjusted mean score ± standard error of the mean;
***p <.01; ***p <.001 for the differences between GPs and psychiatrists;*
▲ p <.05; ▲▲ p <.01 for the differences between the categories of demographic and practice characteristics.

DISCUSSION

A FURTHER LEARNING FROM THE QUALITATIVE AND QUANTITATIVE STUDIES

Both studies have identified that the improvement of collaboration between GPs and psychiatrists encompasses at least two broad dimensions: specific strategies and physician characteristics. As noted earlier, most strategies of collaboration included in the questionnaire evolved from the suggestions that emerged in the qualitative study. Strategies of communication and strategies of CME for GPs in psychiatry were accepted by both GPs and psychiatrists, and were perceived by physicians in the qualitative study as more easily implementable. However, physicians (especially psychiatrists) did not indicate acceptance of the strategies involving on-site collaboration at the primary care level. The degree of acceptance of the proposed strategies is discussed below with respect to the various socio-demographic and practice characteristics of physicians.

In relation to the strategies of communication, both groups of physicians accepted the items that should be included in a GP's consultation request. Nonetheless, GPs expressed less acceptance of these items than psychiatrists. On one hand, the inclusion of the proposed items would provide consulting psychiatrists with detailed information on the referred patient's clinical history, which can facilitate the psychiatric evaluation. On the other hand, GPs may perceive the inclusion of such items as additional work for them, when working under the tight schedules of primary care settings (74,

75). Furthermore, they may not perceive all items as equally important or they may even think that the items involving psychiatric aspects of the patient's history should be investigated and assessed by the consulting psychiatrist (38).

Both groups of physicians accepted the direct information exchange between GPs and psychiatrists, which can take place in the context of a patient referral. In the qualitative study, physicians pointed out that effective communication exchange either on the phone or in writing may avoid additional time and costs in the consultation process, such as further consultation requests or personal contact between physicians. However, effective communication must preserve confidentiality of the information being exchanged. Kates (76) notes, "Increased communication can be a two-edged sword. Sensitive and confidential information can reach individuals who may not be directly involved in patient care." Thus, the content of physicians' notes should include only relevant data which are written in a manner that does not allow specific sentences to be taken or used out of context, and access to a patient's chart should be limited to individuals directly related to the care of the patient (76).

Relative to the strategies of CME for GPs in psychiatry, both GPs and psychiatrists expressed their acceptance of the proposed form to organize traditional CME activities, such as workshops, conferences and briefings. These activities should be interactive and mainly based on themes currently observed in GPs' practices. It is worth noting that interactive CME sessions

that enhance participant activity (such as the format of conferences and workshops described in the qualitative study) can be effective to improve physician performance (concerning counseling, cancer screening, hypertension management, etc.) and, on occasion, patient outcomes (e.g. reduction in patient distress) as well (76A). In addition, physicians in other studies (37, 53, 73, 77, and 78) positively reinforced a practice-based approach for the organization of CME activities.

In Marshall's study (73) about the interaction between GPs and specialists in educational activities, physicians noted that educational activities involving both groups of physicians is a two-way process, where both groups learn from each other, although GPs are often portrayed as the only learners. GPs in the study illustrated this idea of a two-way process with the example that some GPs can teach their specialist colleagues about the benefits of a holistic approach, about teaching methods, and about communication skills (such as interviewing skills). DeGruy (79) reinforces and expands this idea of "two-way process" by describing a cross consultation model where a GP visits a mental health center to provide severe mentally ill individuals with general health care. The visiting GP (as a consulting psychiatrist in primary care settings) can play the role of consultant and educator. In this context psychiatrists may interact with the visiting GP and learn more about the general health of their patients.

Following the same principle of practice-based CME, an important source of CME for GPs was revealed in the psychiatrist's consultation report.

GPs fully accept this statement, especially those not involved in administration, probably because they spend more time seeing patients and can better appreciate the benefits that a specialist's consultation report may bring to their clinical performance. By the same token, older psychiatrists with more years in practice tend to recognize the contribution of the psychiatric consultation report in GPs' daily learning. Non-traditional sources of CME such as interaction between GPs and psychiatrists to discuss shared cases has already been recognized as an accredited educational activity. Describing a pilot project involving a service of consultation-liaison psychiatry for GPs, Meadows (80) explains that The Royal Australian College of General Practitioners recognizes the discussion of cases between GPs and psychiatrists participating in the project as continuing medical education. It awards two CME points per hour, or one point per patient referred.

The benefits (mostly for GPs' practices) of on-site collaboration between primary care physicians and mental health providers have been reported (81, 82, 83). However, GPs and especially psychiatrists did not express complete acceptance of strategies involving on-site collaboration either through consultant psychiatrists practicing in primary care settings or through their periodic visits to such settings. The results of the quantitative study reinforce the idea that most seasoned GPs (with an average of 20 years in practice) might not need or accept a psychiatrist in their offices as a regular consultant and even less as an educator. Despite seeing many patients with

psychiatric problems (1, 4, 5, 17) in their regular practices, GPs may only need a psychiatrist's help in specific situations.

Reviewing some of Goldberg's and Shepherd's studies, Strathdee (84) points out that GPs refer to psychiatrists only a very small number (one in twenty) of their patients with a psychiatric disorder. For example, GPs who participated in the qualitative study stated that they need psychiatrists' support to evaluate and validate their assessment of a patient psychiatric condition, so that the patient's work leave is approved by an insurance company.

As Shepherd and colleagues (1) suggested, GPs' roles as mental health providers should be strengthened, and there is no one better than GPs themselves to express their perceived needs in terms of assistance from psychiatrists. One cannot just consider the generation of studies (24) showing the lack of training of GPs in psychiatry. The population of GPs is extremely diverse in terms of psychiatric skills. Shepherd and colleagues (1) and later Marks and colleagues (30) confirmed this diversity in terms of the detection of psychiatric disorders (some GPs detect more, others detect less).

Other authors reported this diversity in terms of the provision of psychiatric care. Bindman and colleagues (85) studying a pool of GPs responsible for the follow-up of severely mentally ill patients implied that the psychiatric treatment provided by these GPs consisted basically of pharmacotherapy.

Analyzing the responses of 7974 patients, aged 15 to 64 years old, who participated in a retrospective, home-interview survey (The Mental Health

Supplement to the Ontario Health Survey), Lesage and colleagues (6) reported that the mental health treatment provided by primary care physicians involved fewer visits and consisted mostly (57%) of the prescription of psychotropic medication.

Craven and colleagues (86) conducted focus group sessions to learn about the practices of family physicians as mental health care providers. Physicians who had been in community practice for five or more years and had expressed interest in psychosocial problems and mental health care delivery were recruited to the study. The authors reported that most physicians were comfortable with the prescription of antidepressants and with monitoring antipsychotic medication initiated by psychiatrists. Several physicians in the study indicated that they spent time (3 to 5 half or one hour sessions per week) in providing patients with psychotherapeutic interventions, which they defined as supportive counseling.

Psychiatric care provided by physicians in these studies ranged from psychopharmacotherapy (prevailing form of treatment) to "supportive counseling." However, as noted by both GPs and psychiatrists in our qualitative study, many GPs do not deal with patients' psychiatric problems at all. Therefore, it is quite possible that specific groups of GPs might be more likely to participate in collaboration schemes with psychiatrists than others. For example, in the quantitative study GPs working in community settings expressed a tendency to accept more on-site collaboration than their colleagues in hospitals. This may be understood by the fact that GPs

practicing in community settings such as CLSCs may have experienced on-site collaboration with psychiatrists involved in the training of residents in family medicine programs. Female GPs expressed the highest tendency to accept on-site collaboration with psychiatrists, which corroborates Barber's and Williams' (44) finding that female GPs are more open to participating in models of collaboration with mental health providers.

As shown in both qualitative and quantitative studies, psychiatrists in general did not express a favorable opinion about on-site collaboration with GPs in primary care settings. However, psychiatrists, like GPs, do not constitute a homogenous group either. Some psychiatrists seem to be more resistant than others to engage in collaboration schemes with GPs. Contrary to findings in other surveys (84, 87), younger psychiatrists (under 50) expressed the least favorable opinion about on-site collaboration with GPs in primary care settings. Although no significant differences were found between male and female psychiatrists concerning on-site collaboration with GPs, it is worth mentioning that more than half (59%) of psychiatrists under age 50 in the quantitative study were female. In contrast to female GPs, female psychiatrists expressed lower scores in all the proposed strategies, except in the strategy involving the items that should be included in a GP's consultation request.

In French speaking Switzerland, Goerg and colleagues (88), studying gender differences between male and female psychiatrists, identified some reasons which make female psychiatrists differ from their male counterparts.

Female psychiatrists work less hours per week than male psychiatrists and often have to balance professional demands with domestic tasks, pregnancy and child care. Moreover, most of them tend to adopt a theoretical psychological model (involving psychoanalytical concepts), rather than a theoretical eclectic model (involving concepts of social psychiatry) which may encompass collaboration with GPs. Participating psychiatrists (both female and male) in the qualitative study explained that, due to a lack of time and appropriate remuneration, they could not make regular visits to primary care settings.

THE UNDERSTANDING OF DISEASES VERSUS SICK PERSONS

In previous sections, a brief description of the paradigms underlying the quantitative-qualitative dualism was presented in the context of the combination of research methods. However, in the context of medicine, those paradigms provide the basis for another form of dualism: the understanding of diseases vs. sick persons. This understanding varies among physicians and has been expressed in models of medical training and practice. In the following sections, the disease model, the prevailing one in medicine for centuries, is described along with other models of health care delivery. This description consists of an "a posteriori" reflection on collaboration between GPs and psychiatrists. It emerged at the final stage of this research project as an analysis and integration of the qualitative and quantitative studies.

Explaining the evolution of the disease model (which is still the prevailing model in medical reasoning and practices today), McHugh and Slavney (89) compare the writings of Hippocrates (who wrote about sick persons) and Sydenham (who wrote about diseases). These authors examined the work of Henry Sigerist and presented the following quote on sick persons and diseases:

> "(...) Hippocrates recognized only disease, not diseases. He knew only sick individuals (...). The patient and his malady were for him inseparably connected as a unique happening, one which would never recur. But what Sydenham saw above all in the patient, what he wrenched forth to contemplate, was the typical, the pathological process which he had observed in others before and expected to see in others again. In every patient there appeared a specific kind of illness. For him maladies were entities (...)."

In contrast with the Hippocratic thinking about healing a sick person, Sydenham, a seventeenth-century English physician, influenced by the Cartesian thinking of rational analysis, "urged physicians to make careful observations of patients and particularly to note how the symptoms of their illness unfolded so as to differentiate one from another according to its own nature" (89). Sydenham applied to the study of diseases the axiomatic principle that symptoms come in recognizable clusters, and that careful observation of the development and remission of these clusters is the best way to predict the outcome for the patient. McHugh and Slavney (89) also illustrated Sydenham's thinking with the following quote:

> "(...) Nature, in the production of disease, is uniform and consistent; so much so, that for the same disease in different persons the symptoms are for the most part the same; and the selfsame phenomena that you would observe in the sickness of a Socrates you would observe in the sickness of a simpleton. Just so the universal characters of a plant are extended to every individual of the species; and whoever (I speak in the way of illustration) should accurately describe the colour, the taste, the smell, the figure etc., of one single violet would find that his description held good, there or thereabouts, for all the violets of that particular species upon the face of the earth."

McHugh and Slavney (89) explain that Sydenham's thinking influenced the modern medical capacity for identifying and differentiating particular diseases. Once diseases were identified as individual entities, physicians then tried to discern their underlying mechanisms and causes. In the eighteenth century, the Italian physician Morgagni identified the correlation between particular pathological changes in the tissues of the body and specific clinical symptoms and signs. This correlation strengthened the conception of diseases as specific entities which can be associated with the various organs of the body. The next step in the understanding of diseases was to identify the etiological agents causing organic pathology. Concerning infectious diseases, this understanding was achieved through the work of Koch, a nineteenth-century German physician who identified the anthrax bacillus in infected tissues of afflicted patients and devised the fundamental rules by which infectious diseases are to be discovered.

The basic assumption of the disease model is that there is a part of the organic "machine" that is not working well. Thus, the physician must identify the problem (diagnostic) and fix it (treatment). Following this reasoning, physicians will be able to identify and fix any health problem with similar patterns. This caricatured description of the disease model is the conceptual

approach that directs modern medical practices. It implies the notion that diseases are conceptually distinct clinical entities which can be observed, differentiated and classified. Physicians can then identify and treat them in their patients. In this trend of thought, the Hippocratic idea of sick persons is long lost. Signs, symptoms, pathological mechanisms in different organs, and etiological agents are the main concern of medical investigations. In spite of its limits, the disease model is also applied to psychiatric disorders. McHugh and Slavney (89) note that the same medical reasoning (clinical syndrome - pathological process - etiology) is followed in psychiatry. The first step is the identification of a characteristic cluster of psychological signs and symptoms occurring in many patients. The next step is the association of the cluster with a particular neuropathology taking place in the brain. The final step is the identification of etiological factors promoting the pathological process (such as neurotoxicity and genetic defects resulting in abnormal neuronal development and degeneration) in the nervous tissue. The elucidation of the etiology of a given disease may enable its prevention and cure. However, McHugh and Slavney (89) also note an important limit of the disease model in psychiatry: a temptation to presume a brain source for all psychiatric disorders - "a twisted neuron for every twisted thought."

The disease model expanded continually, especially in the decades following World War II (90). In that period advances in fundamental medical research led to great benefits for health care. In psychiatry, for example, the introduction of chlorpromazine (1954) in the treatment of major psychoses,

especially schizophrenia, allowed patients with lifelong hospitalizations to be able to live in community settings (91). As explains Eisenberg (90), the technologic revolution in medical research and its consequent explosion of new knowledge determined the growth of subpecialization in different medical fields. Internal medicine, for example, became increasingly fragmented into subspecialties with an ever narrower focus on one or another aspect of disease biology. In psychiatry, the discovery of new drugs (such as antipsychotic drugs, tricyclic antidepressants and lithium), the re-emergence of diagnosis and classification of disorders (due to the relative specificity of the new therapeutic agents) along with the growing evidence for hereditary transmission of psychosis motivated the rebirth of biologically oriented psychiatry.

It is important to note that the first half of the twentieth century was a period where psychiatric practices were influenced by psychodynamic concepts of treatment. In that period, attention was drawn to the patient's experience as a unique being embedded in feelings, thoughts and behaviors. Efforts were made to understand the meaning of the patient's metaphors throughout the course of his or her illness. An intense doctor-patient relationship was the core of psychiatric practice. As Eisenberg (90) remarks, diagnosis and classification, the hallmarks of the disease model, were almost irrelevant to psychiatric practice, because psychotherapy, the principal method of treatment, dealt with personal issues rather than with diseases.

With the technical revolution described above, this psychiatric practice oriented towards individuals and their life stories was little by little reoriented towards the disease model where "brainless" practices were replaced with "mindless" aspirations (e.g. the causes of psychiatric disorders will be ultimately discovered in the brain, and psychiatry will no more be a marginal medical specialty of Eisenberg's (90) "witch doctors" dealing with obscure maladies and bizarre individuals). Psychiatry may then be included in the mainstream of medicine under the legitimacy of neurology and its brain diseases. Price and colleagues (92) announce that all mental processes are ultimately biological and that any alteration of these processes is biological. Therefore, the everlasting dualism, mind versus brain, nurture versus nature, and functional versus organic should be abandoned. These authors go way beyond this reductionistic announcement and introduce major mental disorders such as schizophrenia, mood disorders, obsessive-compulsive disorder, panic disorder, addiction and autism as biologically based diseases with emerging predictable alterations in genetic coding, structure or functional neuroanatomy. These disorders may be strong candidates for the condition of disease; however, as outlined before, there is still a long way to go so that they fit into the disease model (clinical syndrome - pathological process - etiology). It is worth mentioning that disorder is a clinical syndrome (cluster of symptoms and signs) whose pathological process and etiological agents have not yet been discovered (89).

Eisenberg (90) approaches the disease model in terms of its meaning for patients and physicians. He emphasizes the importance of integrating professional and lay viewpoints, that is, disease and illness. He defines both terms as follows: "Diseases are abnormalities in the structure and/or function of body organs and systems; illnesses, in the patient's world, are experiences of disvalued changes in states of being and in social function." He also defines sickness as being the broad concept that encompasses patient (illness) and the physician (disease) perceptions. These perceptions interpenetrate and influence each other, although only physicians' perceptions (disease) are endorsed by the disease model.

Although not fully inserted in the disease model, biologically oriented psychiatry is endorsed by acclaimed psychiatric periodicals. In the *American Journal of Psychiatry* a variety of articles on neuroscience is published. Some of them are theoretical and propose new paradigms for psychiatry. One (93) describes in detail the ascendancy and decline of psychoanalysis in the U.S., the genetic control of protein synthesis and neuromodulation mechanisms, and even a very interesting definition of individuality based on the interaction of biology and environment. Another (94) attempts to redefine the role of psychiatry in medicine. One point of redefining psychiatry is to rid psychotherapy of psychiatric practice. The authors consider psychotherapy a lower risk and time consuming treatment, which can and should be learned and performed by less expensive non-physician personnel. Psychiatrists should perform physical treatments (such as pharmacotherapy and ECT).

Is it just the biological perspective that matters? What about the different perspectives of psychiatry? Psychiatry is a medical specialty which encompasses disciplines ranging from sociology to biochemistry. Tyrer and Steinberg (95) describe it is a kaleidoscopic field that embraces at least five models of understanding psychiatric problems: the disease, the psychodynamic, the behavioral, the cognitive and the social models. In addition, McHugh and Slavney (89) observe that the capacity to gather a comprehensive body of information on every single patient from history, mental state, physical examination and complementary exams must be a fundamental skill of a competent psychiatrist. Although having a preferred perspective (or model), psychiatrists need to maintain an eclectic identity as clinicians. It is a survival strategy! If psychiatrists confine themselves to a single model of practice, they may easily loose ground with other clinicians. Neurologists can medically treat brain diseases and non medical professionals (such as psychologists, social workers and nurses) can provide patients with psychotherapy.

While psychiatry overemphasizes the disease model, Eisenberg (90) draws attention to the emergence of person-oriented and family-oriented medicine. This comprehensive way of practicing medicine has much of its theoretical basis on the biopsychosocial model proposed by Engel (96) in the late seventies. Engel explains his model as follows:

> "(...) The doctor's task is to account for the dysphoria and the dysfunction which leads individuals to seek medical help, adopt the sick role, and accept the status of patienthood. He must weight the relative contributions of social and psychological factors implicated in the patients' dysphoria and dysfunction as well as in his decision to accept or not patienthood and with it the responsibility to cooperate in his own health care. By evaluating all the factors contributing to both illness and patienthood, rather than giving primacy to biological factors alone, a biopsychosocial model would make it possible to explain why some individuals experience 'illness' conditions which others regard merely as 'problem of living' be they emotional reactions to life circumstances or somatic symptoms. (...) "

Comparing the biopsychosocial model adopted (at least theoretically) by general medicine and psychiatry's orientation towards the disease model, it is not difficult to understand why some GPs in Marshall's study (73) stated that they can teach their specialist colleagues about the benefits of a patient holistic approach!

A FINAL WORD ON COLLABORATION

As outlined above, the disease model, which has guided medical practices for centuries, does not fully incorporate major psychiatric disorders such as schizophrenia and mood disorders. It is less likely then that the disease model helps GPs dealing with the amorphous presentation of psychiatric problems currently found in primary care settings. It appears to be more likely that the biopsychosocial model (96) can help GPs in dealing with a patient's psychiatric problems. However, in the busy pace of primary care practices, how often do GPs have the chance to use Engel's comprehensive model? Moreover, many seasoned GPs were trained and currently practice medicine entirely in the confines of the disease model. Can all GPs be

considered mental health providers? What kind of mental health care can they deliver? As shown in several studies (1, 6, 17, 30, 34, 85, 86), GPs do play a role as mental health providers. But this role varies considerably. It ranges from prescribing (or just monitoring) medication to psychotherapeutic approaches. Mechanic (97), analyzing findings of major epidemiological studies (such as E.C.A. study), draws attention to the peril in the statement that GPs are "a suitable alternative or substitute for more specialized services for the mentally ill." Throughout the article he defends the idea that there is a significant difference in the quality of care received in the specialty sector versus the care received in primary care settings. He even states that some evidence points to the fact that "mental health services provided by the general medical sector are relatively shallow and not well matched with indicators of possible needs." He concludes by pointing out three relevant issues in the broad perception of GPs as key providers of mental health care: a) GPs vary in their interest and sense of responsibility in mental health matters; b) reimbursement systems (such as fee-for-service system) provide strong disincentives for psychosocial services; and c) many GPs feel poorly prepared and uncomfortable in dealing with mentally ill persons.

Strosahl (74) proposes a model to deliver mental health care in primary care settings. This model validates to a certain extent Mechanic's concern about the quality of mental health care provided in the general medical sector. Strosahl (74) describes a primary care mental health care model that is not specialty oriented, but rather is consistent with the goals, strategies, pace and

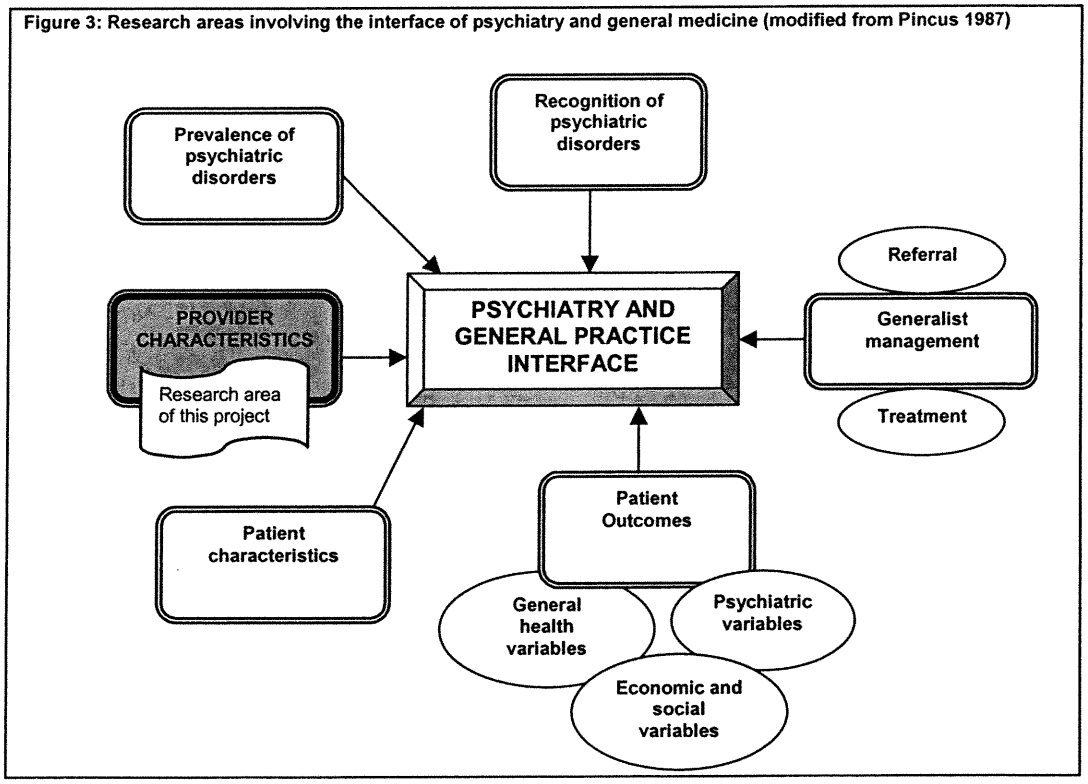
culture of primary care. It involves a behavioral health therapist providing direct consultative services to primary care providers and, where appropriate, engaging in temporary management of patients with primary care providers. The model also involves detecting and addressing a wide range of somatic and mental health problems with the aims of early identification, quick resolution, long-term prevention, and wellness. Consultation visits are brief (15 to 30 minutes) and limited in number (1 to 3 visits). This brief description of this model raises at least one question about how adaptable mental health care can be to the "quick" pace of primary care settings.

Despite the problems involving the interface between psychiatry and primary care settings, collaboration between GPs and psychiatrists is possible. First, Blount's (98) perception of collaboration as a continuum which ranges from occasional courtesy communication at one extreme to on-site collaboration and team work at the other should be recalled. Then it is reasonable to imagine that physicians' perceptions of collaboration can be placed in different points of this continuum. Most physicians seem to perceive collaboration towards the communication extreme and few of them seem to perceive it towards the extreme of on-site collaboration and team work. Therefore, strategies of collaboration involving communication and possibly those involving CME activities for GPs in psychiatry may be accepted by most physicians (both GPs and psychiatrists). However, strategies of on-site collaboration may be only accepted by specific groups of GPs and

psychiatrists who may share several facilitating factors of closer collaboration, including similar understandings of diseases and sick persons.

SUGGESTIONS FOR FUTURE RESEARCH

Pincus (46) summarizes different areas of research involving the interface between psychiatry and general medical settings at the primary care level. Figure 3 below is a modified diagram of Pincus' work to illustrate the extension of this field of investigation and in which research area this project can be inserted.



Both qualitative and quantitative studies in this research project can be associated with the shaded area of *"Provider Characteristics."* These studies

add new information regarding how to improve collaboration between GPs and psychiatrists at three levels: a) communication, b) CME for GPs in psychiatry, and c) access to consulting psychiatrists in primary care settings. Physicians' views on how to improve collaboration led to the identification of several strategies of collaboration. In addition, the attitudinal (acceptability of three groups of strategies), demographic, and practice characteristics of the physicians were identified.

Several studies about the prevalence of psychiatric disorders, the detection of these disorders in the general medical sector, GPs' management of these disorders in terms of referral patterns and treatment, and the impact of this management in patient outcomes have been conducted in the other research areas represented in the diagram. However, little information is available in the areas of provider and patient characteristics (including their views) concerning collaboration between primary care settings and the mental health specialty sector. The investigation of provider and patient characteristics in the context of collaboration between primary care settings and the mental health specialty sector should be expanded.

In June 2001, following the 2nd National Conference on Shared Mental Health Care, the conjoint working group of the Canadian Psychiatric Association and the College of Family Physicians of Canada sponsored a one-day research meeting to organize a national research agenda on collaboration between the primary care and the mental health specialty sectors. In this meeting, one question was recurrently asked: ***"Who does what for whom?"***

This bottom line question might yield valuable information concerning ***who*** are the providers more likely to participate in collaboration schemes, ***what*** kind of mental health services they would be able to provide and for ***whom*** (patients) these services should be provided, that is, who are the patients that would benefit the most from collaboration schemes.

Collaboration schemes can involve professionals other than physicians such as psychologists, nurses and social workers. In Quebec, for example, studies (3, 18) have shown the involvement of psychologists in the delivery of mental health care at the primary care level. In addition, participating GPs in the qualitative study of this project described their collaboration schemes with psychologists. In England, nurses play a strategic role (8) in the delivery of mental health services at the primary care level. Therefore, qualitative research designs involving the triangulation of methods such as in-depth interviews, focus group sessions and participant observation should be envisaged. A study with such design may provide a broad picture of the views of different professional groups (psychologists, nurses and social workers) on collaboration schemes (in terms of working arrangements, roles, mutual expectations, barriers and suggestions for improved collaboration) in primary care settings or between the primary care and the mental health specialty sectors.

Surveys similar to the one conducted in this research project could be of interest to other Canadian provinces. Further administration of the questionnaire especially designed for the survey in this project would increase

its validity and would allow broader generalization of the results obtained. Studies (qualitative, quantitative, or both) involving GPs and psychiatrists should also investigate their views about mental health services that can be offered in primary care settings, and about the profile of patients to whom these services should be available.

As stated before, information on patient characteristics is also necessary. The diversity of psychiatric patients in the community or attending care in different health care settings should often be considered and highlighted in any investigation involving these patients. Describing pathways to psychiatric care, Goldberg and Huxley (17) provide an overview of psychiatric patients. The population of these patients seems to be quite diverse.

Nonetheless, the main representation of psychiatric patients is still oriented towards severely mentally ill patients (mainly psychotic patients). This representation is pictured not only in lay people's minds. It also seems to be shared by health providers, planners and even researchers. Severe mentally ill patients constitute only a small portion (1% to 3%) of the general population receiving mental health care. They must continue to receive the care they need. However, in addition, attention should be drawn to the "hidden psychiatric morbidity" in the community as well as in the general medical sector worldwide (99). Therefore, researchers conducting any study involving patients and collaboration schemes should highlight the diversity of psychiatric patients in order to expand and update the social representation

about these patients. As a result, it is possible that the proportion of psychiatric patients seeking and receiving the assistance they need would increase.

In addition to this contribution to the update of a social representation, studies should collect patients' views on collaboration schemes involving professionals (physicians and non-physicians) in different health care sectors (primary care and mental health specialty). Researchers should identify who are the patients that would accept and benefit the most from collaboration schemes involving physicians and other health professionals. Who are those patients whose perception of health care fits better in the disease model or in the biopsychosocial model? The disease model delegates to physicians the exclusive task of "healing" patients. Patients are expected to be healed and not to participate in the healing process. In contrast, in the biopsychosocial model patients are expected to cooperate in their own health care. It is worth noting that the concept of patients being considered as physicians' partners in their health care is considerably developed. Savard (100) devised *The Savard Health Record* which consists of a file folder where patients keep a variety of information about their health care. Patients can gather information on their medical history, prescriptions, results of medical exams, participation on prevention programs and so forth. The folder includes a very clear and concise manual on how patients can better organize their medical information. It contains even a glossary on common medical conditions and terms as well as common medical record abbreviations.

Another subject that should be investigated in this research area is the transfer of patients from the mental health sector to the general medical sector or vice-versa. How do patients perceive this transfer? What are their views on the links (such as the doctor-patient relationship) that they have already established with providers in a given sector? In their views, how disruptive would a transfer be to those links? Answers to these questions should be available in the context of shared care programs where the main focus is to transfer severe mentally ill patients (mainly compensated psychotic patients) from the mental health sector to the care of GPs in primary care settings, as is the case in the program described by Meadows (80) in Australia.

Despite all the information still needed from the views of providers and patients about how to improve collaboration, this research project has unveiled pieces of information that should be considered in the process of improving collaboration between GPs and psychiatrists.

CONCLUSION

The improvement of collaboration between psychiatrists and GPs can be achieved through groups of strategies. GPs and psychiatrists in general express a positive opinion concerning strategies to improve their communication and practice-based CME activities for GPs in psychiatry. The implementation of these strategies is perceived to depend on local initiatives. Further, they are seen in a positive light because they cause only minimal disruption to well established clinical practices. Strategies involving the improvement of GPs' access to consulting psychiatrists in primary care settings elicit less positive opinions, especially among psychiatrists. The implementation of these strategies is perceived to require major changes in clinical practices for most GPs and psychiatrists. These strategies seem to be viable among specific groups of physicians who share common views of health care delivery. Indeed through collaboration schemes GPs and psychiatrists along with other health care providers may be better able to meet the increasingly complex demands of the diverse population of psychiatric patients.

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APPENDICES

GUIDE FOR THE IN-DEPTH INTERVIEWS

GPs' and psychiatrists' versions

GUIDE FOR THE IN-DEPTH INTERVIEWS - GPs' VERSION

Questions des entrevues individuelles

VERSION OMNIPRATICIEN

1. **(Rôle)** Dans sa pratique, le médecin généraliste rencontre beaucoup de patients dont le problème de santé touche, en tout ou en partie, le domaine de la santé mentale. Comment percevez-vous le rôle du médecin généraliste à ce niveau?

2. **(Rapport de travail)** En lien avec ce que vous avez dit jusqu'à présent sur le travail du médecin généraliste dans le domaine de la santé mentale, j'aimerais que vous parliez plus spécifiquement de vos rapports avec les médecins psychiatres.

3. **(Satisfaction)** Êtes-vous satisfait de vos rapports de travail avec eux ? (Pourriez-vous préciser ?)

4. **(Attentes)** Quel genre d'aide ou de soutien des médecins psychiatres aimeriez-vous recevoir pour faciliter votre travail auprès de vos patients ?

5. **(Barrières)** Quelles sont d'après vous les principales barrières pour établir ce genre de collaboration avec les psychiatres ?

6. **(Suggestions)** Que faudrait-il faire pour rendre possible le genre de collaboration que vous souhaitez avec les psychiatres ?

7. **(Convergence \ divergence)** Diriez-vous que la plupart de vos collègues (généralistes) partageraient les opinions que vous avez exprimées? Le cas échéant, pourriez-vous m'indiquer ce qui seraient les principaux points de convergence ou de divergence ?

GUIDE FOR THE IN-DEPTH INTERVIEWS - PSYCHIATRISTS'S VERSION

Questions des entrevues individuelles

VERSION PSYCHIATRE

1. **(Rôle)** Dans sa pratique, le médecin généraliste rencontre beaucoup de patients dont le problème de santé touche, en tout ou en partie, le domaine de la santé mentale. Quel genre d'aide ou de soutien pourriez-vous offrir aux médecins généralistes pour faciliter leur travail auprès de leurs patients?

2. **(Rapport de travail)** En lien avec ce que vous avez dit jusqu'à présent sur le travail avec le médecin généraliste dans le domaine de la santé mentale, j'aimerais que vous parliez plus spécifiquement de vos rapports avec les médecins généralistes.

3. **(Satisfaction)** Êtes-vous satisfait de vos rapports de travail avec eux?(Pourriez-vous préciser ?)

4. **(Attentes)** Qu'attendez-vous des médecins généralistes pour rendre possible un rapport de collaboration avec les psychiatres?

5. **(Barrières)** Quelles sont d'après vous les principales barrières pour établir ce genre de collaboration avec les médecins généralistes?

6. **(Suggestions)** Que faudrait-il faire pour rendre possible le genre de collaboration que vous souhaitez avec les médecins généralistes?

7. **(Convergence \ divergence)** Diriez-vous que la plupart de vos collègues (psychiatres) partageraient les opinions que vous avez exprimées? Le cas échéant, pourriez-vous m'indiquer ce qui seraient les principaux points de convergence ou de divergence ?

GUIDE FOR THE FOCUS GROUP SESSION

Facilitator's and participants' versions

GUIDE FOR THE FOCUS GROUP SESSION - FACILITATOR'S VERSION

GUIDE DE DISCUSSION (Version animateur)

GROUPE DE DISCUSSION PORTANT SUR LES SOINS PARTAGÉS PSYCHIATRIQUES

MONTRÉAL, LE 9 AVRIL 1999
(13 h à 15 h)

1. Présentation de l'animateur et de l'objectif de la rencontre

- Objectif de la rencontre

  Engager la discussion sur la synthèse des résultats, selon les 5 dimensions des soins partagés psychiatriques (rapports de travail, rôles, barrières, attentes et suggestions), abordées dans l'étude, afin d'atteindre de nouveaux insights sur les résultats des entrevues individuelles et du document *«Les soins de santé mentale partagés au Canada»*, ainsi que mieux les expliquer, les compléter, les élargir et les confirmer.

- Tour de table et présentation des participants **10 minutes**

2. Discussion sur les rapports de travail entre généralistes et psychiatres

***Quels sont vos commentaires sur la description des rapports de travail dans la synthèse des résultats? Qu'est-ce qu'on peut ajouter à cette description pour la compléter, pour l'élargir, pour l'expliquer, pour la confirmer?**

I. Diriez-vous que les rapports de travail entre les généralistes et les psychiatres se déroulent souvent au niveau écrit, non-personnalisé et dans le cadre d'un processus de référence d'un patient et qu'ils ne se rencontrent presque jamais?

II. Diriez-vous que, lorsqu'il y une interaction personnelle et régulière au niveau clinique entre les généralistes et les psychiatres, celle-ci arrive toujours dans le cadre de l'enseignement?

III. Peut-on dire que le niveau de satisfaction actuel des psychiatres et des généralistes en ce qui concerne leurs rapports de travail est considérablement faible?

IV. Quels sont les professionnels non-médecins qui travaillent en collaboration avec les généralistes et les psychiatres en ce qui concerne les patients psychiatriques? Que font plus particulièrement ces autres professionnels?

20 minutes

3 Rôles perçus et attendus des généralistes et des psychiatres

A) Rôles perçus (généralistes)

***Quels sont vos commentaires sur la description des rôles perçus par chacun des médecins, généralistes et psychiatres, à partir de la synthèse des résultats? Qu'est-ce qu'on peut ajouter à cette description pour la compléter, pour l'élargir, pour l'expliquer, pour la confirmer?**

I. Peut-on dire que le généraliste perçoit un de ses rôles comme étant celui d'être responsable de poser un diagnostic et de mener l'approche thérapeutique, soit au niveau de la médication soit au niveau de la relation médecin-patient?

II. Perçoit-il également son rôle comme celui d'assumer le suivi à long terme de certains patients psychiatriques? Quels sont ces patients (les troubles de l'humeur, d'anxiété, de somatisation, d'adaptation, de personnalité, les troubles mentaux chroniques stables, quelques cas aigus...)?

III. Est-ce qu'on peut dire que le généraliste perçoit aussi son rôle d'intervenant au niveau de l'éducation du patient et de sa famille en ce qui concerne les troubles mentaux?

B) Rôles perçus (psychiatres)

I. Peut-on dire que le psychiatre se perçoit comme un consultant et un éducateur face aux généralistes?

II. Est-ce qu'on peut dire que le psychiatre perçoit également son rôle comme clinicien, responsable d'assumer le suivi de certains cas psychiatriques, tels que les cas psychiatriques sévères, compliqués ou réfractaires au traitement qui exigent les soins de santé secondaires ou tertiaires?

III. Peut-on affirmer que le psychiatre a un rôle à jouer au niveau de la psychothérapie? Lequel?

C) Rôles attendus (généralistes)

***Quels sont vos commentaires sur la description des rôles attendus de chacun des médecins, généraliste et psychiatre, à partir de la synthèse des résultats? Qu'est-ce qu'on peut ajouter à cette description pour la compléter, pour l'élargir, pour l'expliquer, pour la confirmer?**

I. Est-ce qu'on peut dire qu'un de rôles attendus par rapport au généraliste est d'assurer la continuité des soins de santé, comme pourvoyeur primordial, pour les patients psychiatriques avec le soutien du psychiatre?

II. Un autre rôle attendu est-il également de fournir plus d'information au psychiatre à propos d'un patient et préciser le but de la demande de consultation?

III. Peut-on dire aussi qu'un de rôles attendus par rapport aux généralistes est d'accepter les appels du personnel non-médical?

D) Rôles attendus (psychiatres)

I. Un des rôles attendus par rapport aux psychiatres est-il d'être disponible pour une consultation rapide?

II. Est-ce qu'on peut dire qu'un des rôles attendus par rapport aux psychiatres est également celui d'éducateur des généralistes et des autres spécialistes à travers la consultation?

III. Peut-on affirmer aussi qu'un de rôles attendus par rapport aux psychiatres est d'assumer la prise en charge de patients psychiatriques envers lesquels le généraliste n'est pas confortable d'assumer le suivi en première ligne?

20 minutes

4. Principales barrières, freins et difficultés à l'exécution efficiente des tâches

***Quels sont vos commentaires sur la description des barrières dans la synthèse des résultats? Qu'est-ce qu'on peut ajouter à cette description pour la compléter, pour l'élargir, pour l'expliquer, pour la confirmer?**

*Quelles sont les principales barrières dans la synthèse des résultats qui vous empêchent d'améliorer le travail quotidien avec votre partenaire médecin (généraliste ou psychiatre) et avec les patients psychiatriques dans le cadre des soins partagés psychiatriques?

*Quelles sont les barrières les plus urgentes à surmonter? Quelles sont les moins difficiles? Quelles sont les plus difficiles? Pourquoi?

20 minutes

5. Principales attentes des généralistes et des psychiatres

***Quels sont vos commentaires sur la description des attentes réciproques des généralistes et des psychiatres à partir de la synthèse des résultats? Qu'est-ce qu'on peut ajouter à cette description pour la compléter, pour l'élargir, pour l'expliquer, pour la confirmer?**

A) Généralistes

I. Est-ce que les généralistes s'attendent à ce que les psychiatres leur offrent une consultation rapide (dans un intervalle maximal de 15 jours), dans un cadre autre qu'à l'institution et qu'ils envoient toujours un rapport de consultation aux généralistes?

II. Les généralistes s'attendent-ils à ce que les psychiatres les avisent quand ils décident de prendre en charge les soins psychiatriques d'un patient? Et est-ce les généralistes s'attendent à ce que certains patients aient accès à la psychothérapie?

III. Les généralistes s'attendent-ils également à ce que les psychiatres participent à leur éducation continue, à travers le rapport de consultation, à travers les stages de formation à Louis H., à travers la formation en psychothérapie et à travers l'organisation conjointe de journées scientifiques, de conférences et d'ateliers?

B) Psychiatres

I. Est-ce que les psychiatres s'attendent à ce que les généralistes leur fournissent plus d'information sur l'histoire d'un patient et sur leurs attentes par rapport à la consultation lors de la référence du patient en psychiatrie?

II. Les psychiatres s'attendent-ils à ce que les généralistes prennent en charge les patients psychiatriques chroniques stables et ceux atteints d'un trouble mental transitoire d'intensité légère ou modérée, tout en ayant accès rapidement à un psychiatre?

15 minutes

6. Suggestions d'amélioration pour un meilleur rapport généralistes et psychiatres

***Quels sont vos commentaires sur la description des suggestions à partir de la synthèse des résultats? Qu'est-ce qu'on peut ajouter à cette description pour la compléter, pour l'élargir, pour l'expliquer, pour la confirmer?**

*Quelles sont les suggestions les plus urgentes à considérer? Quelles sont celles qui peuvent être implantées plus facilement et qui peuvent avoir un impact considérable en ce qui concerne les soins partagés psychiatriques? Quelles sont les suggestions les plus difficiles à implanter? Pourquoi?

20 minutes

7. Retour avec les participants et mot de la fin

10 minutes

GUIDE FOR THE FOCUS GROUP SESSION - PARTICPANTS' VERSION

GUIDE DE DISCUSSION (Version participant)

GROUPE DE DISCUSSION PORTANT SUR LES SOINS PARTAGÉS PSYCHIATRIQUES

MONTRÉAL, LE 9 AVRIL 1999
(13 h à 15 h)

1. Présentation de l'animateur et de l'objectif de la rencontre

2. Discussion sur les *RAPPORTS DE TRAVAIL* entre généralistes et psychiatres

*Quels sont vos commentaires sur la description des rapports de travail dans la synthèse des résultats? Qu'est-ce qu'on peut ajouter à cette description pour la compléter, pour l'élargir, pour l'expliquer, pour la confirmer?

3 *RÔLES PERÇUS ET ATTENDUS* des généralistes et des psychiatres

A) Rôles perçus (généralistes et psychiatres)

*Quels sont vos commentaires sur la description des rôles perçus par chacun des médecins, généralistes et psychiatres, à partir de la synthèse des résultats? Qu'est-ce qu'on peut ajouter à cette description pour la compléter, pour l'élargir, pour l'expliquer, pour la confirmer?

B) Rôles attendus (généralistes et psychiatres)

*Quels sont vos commentaires sur la description des rôles attendus de chacun des médecins, généraliste et psychiatre, à partir de la synthèse des résultats? Qu'est-ce qu'on peut ajouter à cette description pour la compléter, pour l'élargir, pour l'expliquer, pour la confirmer?

4. Principales *BARRIÈRES*, freins et difficultés à l'exécution efficiente des tâches

*Quels sont vos commentaires sur la description des barrières dans la synthèse des résultats? Qu'est-ce qu'on peut ajouter à cette description pour la compléter, pour l'élargir, pour l'expliquer, pour la confirmer?

5. Principales ***ATTENTES*** des généralistes et des psychiatres

*Quels sont vos commentaires sur la description des attentes réciproques des généralistes et des psychiatres à partir de la synthèse des résultats? Qu'est-ce qu'on peut ajouter à cette description pour la compléter, pour l'élargir, pour l'expliquer, pour la confirmer?

6. ***SUGGESTIONS*** d'amélioration pour un meilleur rapport généralistes et psychiatres

*Quels sont vos commentaires sur la description des suggestions à partir de la synthèse des résultats? Qu'est-ce qu'on peut ajouter à cette description pour la compléter, pour l'élargir, pour l'expliquer, pour la confirmer?

7. Retour avec les participants et mot de la fin

CODING SYSTEM (list of codes)

LEXIQUE DES CODES

1. Rôle

1.1 R-omni.P (rôle omnipraticien perçu): ce code s'applique aux citations dans lesquelles l'omni décrit le rôle qu'il joue auprès des patients atteints de maladie mentale. Par exemple, ce rôle peut consister à « répéter la prescription de psychotropes pour les malades aux prises avec des troubles mentaux sévères ».

1.2 R-omni.A (rôle omnipraticien attendu): ce code réfère aux citations décrivant le rôle attendu et/ou recommandé que devrait jouer l'omni auprès des patients atteints de maladie mentale. Par exemple, les attentes et les recommandations des associations des médecins (l'Association des psys du Canada, le Collège des médecins de famille du Canada, etc.).

1.3 R-psy.P (rôle psychiatre perçu): ce code s'applique au rôle perçu par le psy comme étant le rôle à jouer auprès des omnis qui traitent de patients souffrant de maladie mentale. Par exemple, il peut s'agir d'un rôle de « consultant et /ou d'éducateur pour l'omni » ou de « donner du suivi seulement au patients atteints d'une maladie mentale sévère ».

1.4 R-psy.A (rôle psychiatre attendu): ce code se rapporte aux citations décrivant le rôle attendu et/ou recommandé que devrait jouer le psy auprès des omnis qui traitent de patients atteints de maladie mentale. Par exemple, les attentes et les recommandations des associations des médecins (l'Association des psys du Canada, le Collège des médecins de famille du Canada, etc.).

2. Rapport de Travail

2.1. Rap.trav0: ce code illustre l'absence de rapport de travail entre les omnis et les psys.

2.2. Rap.trav1: ce code s'applique aux citations où l'on décrit le rapport de travail omni/psy, ses barrières, ses avantages etc. Il permet aussi d'expliquer le processus de référence d'un patient (qui est référé au psy par l'omni) et de décrire les différents types d'omni.

2.3. Rap.trav2: ce code décrit le rapport de travail entre l'omni ou le psy et un autre professionnel, comme les psychologues, les travailleuses sociales, d'autres spécialistes de la médecine etc.

2.4 Rap.trav3: ce code s'applique aux citations qui font état de la satisfaction à l'égard du rapport de travail.

3. Omni Bien Placé

3.1. Omni Bien Placé0: ce code s'applique aux citations où il est question de la place privilégiée que l'omni occupe dans le système de santé pour dispenser des soins en santé mentale (pour aider la majorité des patients atteints). Plusieurs raisons peuvent expliquer la position privilégiée de l'omni : omni plus accessible, omni connaît ses patients, omni bien placé pour voir le patient comme un tout et pour considérer l'unité physique/mentale etc..

3.2. Omni Bien Place1: ce code se rapporte aux citations où l'on indique que l'omni représente une image moins menaçante ou plus positive que le psychiatre.

- **Association**: Omni Bien Place1 x B-Prejuge

4. Inter.SM (Intérêt en santé mentale): ce code se rapporte aux citations où il est question de l'intérêt des omnis en santé mentale ou face aux soins partagés, par exemple, les omnis intéressés par la SM ou par les SP. Il s'applique aussi aux citations où l'omni affirme prendre en charge ses ptes psys. Par conséquent, le suivi du pte est assuré.

5. Voie.comuni (voie de communication): ce code se rapporte aux citations où on décrit la façon dont les omnis et les psys communiquent entre eux.

6. Barrières

6.1. B-class.psy (classification psychiatrique): ce code s'applique aux citations où il est question des problèmes résultant de l'utilisation des classifications psychiatriques pour établir un diagnostic, par exemple, le DSM IV. Il peut aussi être attribué aux problèmes liés à la complexité de la terminologie psychiatrique et aux modifications dont elle a été l'objet à travers le temps.

6.2. B-confid (confidentialité): ce code fait référence aux citations où la confidentialité est décrite comme étant une barrière à la communication et à la collaboration entre les omnis et les psys. En effet, certains omnis et psys ne se sentent pas à l'aise d'échanger des informations sur le cas d'un patient en raison de son caractère confidentiel.

- **Association:** B-confid x B-manq.comuni.

6.3. B-manq.def.role / model / resp / att (manque de définition de rôles, de modèles, de responsabilités et d'attentes): ce code réfère aux citations qui présentent le manque de définition face aux responsabilités (et rôles) respectives de l'omni et du psy comme étant une barrière à la communication,

à la collaboration et à la définition des attentes entre ces deux catégories de médecins. Ce code se rapporte également aux divisions arbitraires de patients. Par exemple, «les psys s'occupent de la psychiatrie lourde et les omnis, des petits cas» ou «l'hôpital psychiatrique pour les psychotiques, le CLSC pour les non-psychotiques».

6.4. B-dif.acces (difficulté d'accès)

***6.4.1. B-dif.acces0**: ce code illustre la difficulté d'accès à un psychiatre, à un service psychiatrique ou à n'importe quel professionnel de la santé mentale. Il correspond aussi aux listes d'attente, aux causes ainsi qu'aux conséquences liées à la difficulté d'accès aux soins psychiatriques (notamment, à la psychothérapie).

***6.4.2. B-dif.acces1**: Ce code s'applique aux citations où on parle de la dichotomie des extrêmes: urgence / liste d'attente;

- **Association:** B-dif.acces1 x les codes B-manq.def.role/model/resp/att et S-def.role/model/resp/att

***6.4.3 B-dif.acces2**: ce code fait état des critères d'admission à un service de santé mentale.

6.5. B-manq.comuni (manque de communication): ce code réfère aux citations où il est question des problèmes résultant du manque de communication entre les omnis et les psys. Ce code s'applique aussi à l'explication des causes de ce manque de communication.

- **Association:** B-manq.comuni x B-manq.def.role / model / resp / att, B-confid et B-manq.contact

6.6. B-manq.contact (manque de contact personnel): ce code s'applique aux citations où on parle du manque de contact personnel entre les omnis et les psys. Ce code peut également être attribué aux causes et/ou aux conséquences de ce manque de contact.

6.7. B-manq.inter/comp/form (manque d'intérêt, de compétence, de formation): ce code est destiné aux citations où les omnis ou les psys expriment un manque d'intérêt, de compétence et/ou de formation par rapport aux soins partagés en santé mentale. Ce code s'applique également aux citations où les omnis font part de leur manque d'intérêt, de compétence et/ou de formation en santé mentale. Il réfère, aussi, aux citations où il est question des problèmes liés à la formation médicale de base et/ou à la résidence médicale, soit pour le psy ou pour l'omni.

- **Association:** B-manq.inter/comp/form x . B-manq.contact, B-manq.comuni, B-manq.suivi, B-prejuge

6.8. B-planification:

***6.8.1 B-planification0**: ce code se rapporte aux citations où on fait mention de n'importe quel macro changement dans le système de santé tels les reformes (reforme de services de santé mentale), les coupures budgétaires, le virage ambulatoire etc. Il s'applique aux changements ayant eu lieu dans la société (chômage, violence, etc.). Ce code réfère également aux problèmes associés à l'exercice de la médecine (par exemple, les omni qui ne font que de la psychothérapie, les omnis qui travaillent comme s'ils étaient spécialistes), ainsi qu'aux conflits entre les médecins. Pour le manque de reconnaissance du rôle de l'omnipraticien dans le plan de soins d'un patient psy.

***6.8.2 B-planification1**: ce code s'applique aux citations où on mentionne le manque d'effectif et/ou les effectifs surchargés. Pour les citations, où on parle de la question de l'omni être bon en tout sans que ses limites soient respectées.

***6.8.3 B-planification2**: ce code réfère aux citations où on décrit les problèmes d'administration et d'organisation des services de santé. ex.: la sectorisation. Il s'applique, aussi, aux problèmes rencontrés par les équipes de santé mentale (Dr Charles, Dr Christine) ainsi qu'aux problèmes empêchant le psy ou l'omni à se déplacer (chez l'omni, chez le psy, chez le patient, ect.).

6.9. B-remuneration (rémunération de médecins, système de rémunération, etc.)

***6.9.1 B-remuneration0**: ce code s'applique à n'importe quelle citation qui présente les systèmes de rémunération comme une barrière aux soins partagés (concerne les barrières générales associées à la rémunération des soins partagés).

***6.9.2 B-remuneration1**: ce code réfère aux problèmes de rémunération liés au temps requis à la consultation d'individus atteints de maladie mentale. Par exemple, les omnis traitent plus de cas d'hypertension que de cas de dépression. Ils voient plus de patients souffrant d'hypertension que de dépression dans une même période de temps pour des questions monétaires.

6.10. B-Préjugé (préjugé): ce code se rapporte aux citations où il est question des préjugés, notamment à l'égard des services de santé mentale, des psys, des patients atteints, etc.

6.11. B-temps\cons\SM (temps de consultation en santé mentale): ce code réfère aux citations où il est question de l'importante quantité de temps devant

être allouée aux patients psychiatriques. Le code s'applique aussi aux conséquences de cette exigence de plus de temps avec un patient. Les choses se règlent lentement en psychiatrie.

- **Association:** B-temps\cons\SM x B-remuneration1

6.12. B-med.fast.food (médecine fast food): ce code illustre l'actuelle crise médicale où le principe de quantité prévaut sur celui de qualité. C'est la productivité qui compte avant tout. Par exemple, plus un médecin voit de patients, plus il est compétent. Ce code s'applique aussi aux citations qui font référence aux dimensions suivantes: a) la perte de qualité de la relation médecin-patient résultant de l'exigence de productivité dans la pratique médicale; b) le manque de valorisation du médecin résultant d'une consultation plus longue et, parfois, de meilleure qualité; c) n'importe quelle citation liée à l'hyper valorisation de la médecine d'urgence.

6.13. B-manq.suivi (manque de suivi): ce code s'applique aux citations où les médecins travaillant à l'urgence (E.R.) ne se sentent pas responsables du suivi des patients, notamment de ceux atteints de maladie mentale. Ce code se rapporte aussi aux citations qui font référence au « dispatching ».

- **Association:** B-préjugé, B-manq/inter/comp/form, B-rémunération0

6.14. B-manq.partenariat (manque de partenariat): ce code se rapporte à toutes les citations où on fait état du manque et/ou du besoin de partenariat ainsi que des causes et/ou des conséquences de ce manque/besoin de partenariat, de collaboration des soins partagés entre les omnis et les psys. Il fait également référence aux citations où il est question du psy qui «garde» les ptes sans les retourner à l'omni. Pour les citations, où il y a un besoin de partenariat entre l'omni et le psy, à cause des arrêts de travail.

- **Association:** B-manq/inter/comp/form

7. Att.omni (attentes de l'omnipraticien)

- **Association**: Rôle attendu x Attentes

7.1. Att.omni0: ce code s'applique aux citations faisant état de l'absence d'attente et de besoin des omnis face au psys.

7.2. Att.omni1: ce code fait références aux attentes suivantes : support du psy en général; psy consultant accessible; psy évalue le patient dans un délai raisonnable; psy et omni évaluent le patient conjointement; psy précise le diagnostic; psy précise le traitement et le pronostic; psy émet des recommandations quant au suivi d'un patient; psy donne des recommandations pour les cas résistants aux traitements, pour les complications aux traitements; psy offre des services aux ptes (par exemple, la psychothérapie). Il s'applique également aux attentes des omnis en général.

7.3. Att.omni2: ce code se rapporte aux attentes suivantes : psy sort de l'institution; psy fait des visites au domicile des patients; psy se rend au bureau de l'omni.

7.4. Att.omni3: ce code se destine aux attentes suivantes : psy agit à titre d'éducateur; psy participe à la formation de l'omni en santé mentale; psy organise des journées de formation conjointement avec les omnis et ce, en fonction de leurs besoins; psy donne des informations sur les ressources disponibles en santé mentale tant au niveau de soins primaires (ressources dans la communauté) et secondaires que tertiaires;

- **Association:** att.omni3 et S-form2.

8. Att-psy (attentes du psychiatre)

- **Association**: Rôle attendu x Attentes

8.1. Att.psy0: aucune attente, aucun besoin.

8.2. Att.psy1: omni prend en charge les patients atteints de maladie mentale qui peuvent être soignés dans les services de première ligne; omni travaille avec les ressources communautaires et le psy à la fois; omni rédige une lettre de référence plus détaillée. Ce code peut aussi être attribué aux attentes des psys en général.

- **Association**: Rôle attendu x Attentes

9. SUGGESTIONS

9.1. S-amelior/comuni (améliorer la communication)

***9.1.1 S-amelior/comuni0**: ce code réfère aux suggestions générales qui sont proposées pour améliorer la communication ou à n'importe quelle autre suggestion qui n'est ni incluse en **S-amelior/comuni1** ni en **S-amelior/comuni2**.

***9.1.2 S-amelior/comuni1**: ce code s'applique aux suggestions visant à améliorer la communication à travers le contact personnel dans le cadre de congrès, de conférence, de visites au bureau des omnis etc.

***9.1.3 S-amelior/comuni2**: ce code est attribué aux suggestions visant à améliorer la communication à travers des points de repère définis. Par exemple, avoir le nom, le numéro de téléphone et le secteur de la personne (médecin, psychologue, travailleuse sociale, etc.) avec qui on va communiquer.

9.2. S-def.role/model/resp/att (suggestion de définition des rôles, des modèles, des responsabilités et/ou des attentes): ce code s'applique à n'importe quelle suggestion de définition des rôles, des responsabilités et des attentes des omnis par rapport aux psys et vice-versa, toujours dans le

contexte des soins partagés. Il réfère aux suggestions visant à définir des modèles de collaboration entre les omnis et les psys. Ce code fait aussi référence aux suggestions de division des patients, comme, par exemple, la suggestion d'élaborer des critères de sévérité des maladies mentales et de partager les malades mentaux entre les omnis et les psys, selon ces critères.

- **Association**: S-def.role/model/resp/att x B-manq.def.role / model / resp / att ⇒⇒⇒ Il faut remarquer que la division arbitraire des ptes est une barrière au SP, tandis que la suggestion de division des ptes peut être une suggestion d'amélioration / implémentation des SP.

9.3. S-form (formation):

***9.3.1 S-form0**: ce code s'applique à n'importe quelle suggestion visant l'amélioration de la formation au niveau du premier cycle.

***9.3.2 S-form1**: ce code réfère à n'importe quelle suggestion visant l'amélioration de la formation au niveau de la résidence médicale.

***9.3.3 S-form2**: ce code peut être attribué à n'importe quelle suggestion destinée à l'amélioration de la formation au niveau des programmes d'éducation continue (pour les professionnels qui pratiquent déjà la médecine) ou à n'importe quelle suggestion de formation en générale pour les omnis ou pour les psys.

9.4. S-suivi: ce code s'applique aux suggestions de suivi des individus atteints de maladie mentale soit par l'omni soit par le psy.

9.5. S-partenariats (partenariat)

***9.5.1 S-partenariats0**: ce code se rapporte aux stratégies d'implémentation des soins partagés ainsi qu'à leurs conséquences positives. Il réfère également aux suggestions de formation d'équipes de santé mentale (CLSC, cliniques externes).

***9.5.2 S-partenariats1**: ce code réfère aux suggestions de partenariat entre les départements de psychiatrie et de médecine familiale.

9.6. S-recherche (recherche et élaboration de documents): ce code peut être attribué à n'importe quelle suggestion liée à la recherche ou à la préparation de documents destinés aux soins partagés.

9.7. S-remuneration (rémunération de médecins, système de rémunération, etc.): ce code s'applique à n'importe quelle suggestion de rémunération en matière de soins partagés (suggestions liées à la rémunération pour mettre en œuvre et/ou améliorer les initiatives de soins partagés).

9.8 S-Planification

***9.8.1 S-Planification0**: ce code se rapporte aux suggestions d'organisation et d'amélioration du système de santé dans son ensemble. Il réfère aux suggestions de formation de groupes de travail dans les associations de psys et d'omnis pour coordonner et surveiller les projets portant sur les soins partagés. Il s'applique aussi aux suggestions liées à la prévention de façon à éviter la détérioration, la décompensation des cas psychiatriques, au lieu de maintenir la dichotomie urgence/liste d'attente. Enfin, il peut être attribué aux suggestions visant à améliorer l'accès aux soins psychiatriques;

***9.8.2 S-Planification1**: ce code s'applique aux suggestions visant à augmenter les effectifs;

***9.8.3 S-Planification2**: ce code fait référence aux suggestions liées à l'organisation, à l'amélioration d'un service donné. Il peut aussi être attribué aux suggestions visant l'assouplissement de la sectorisation.

10. Convergence \ divergence

10.1 Point.conv.omni (Point de convergence-omni): ce code s'applique aux citations décrivant les points de convergence parmi les omnis.

10.2 Point.div.omni (Point de divergence-omni): ce code concerne les citations faisant état des points de divergence parmi les omnis.

10.3 Point.conv.psy (Point de convergence-psy): ce code s'applique aux citations décrivant les points de convergence parmi les psys.

10.4 Point.div.psy (Point de divergence-psy): ce code concerne les citations faisant état des points de divergence parmi les psys.

FLOWCHART FOR THE QUESTIONNAIRE DEVELOPMENT

FLOWCHART FOR THE QUESTIONNAIRE DEVELOPMENT

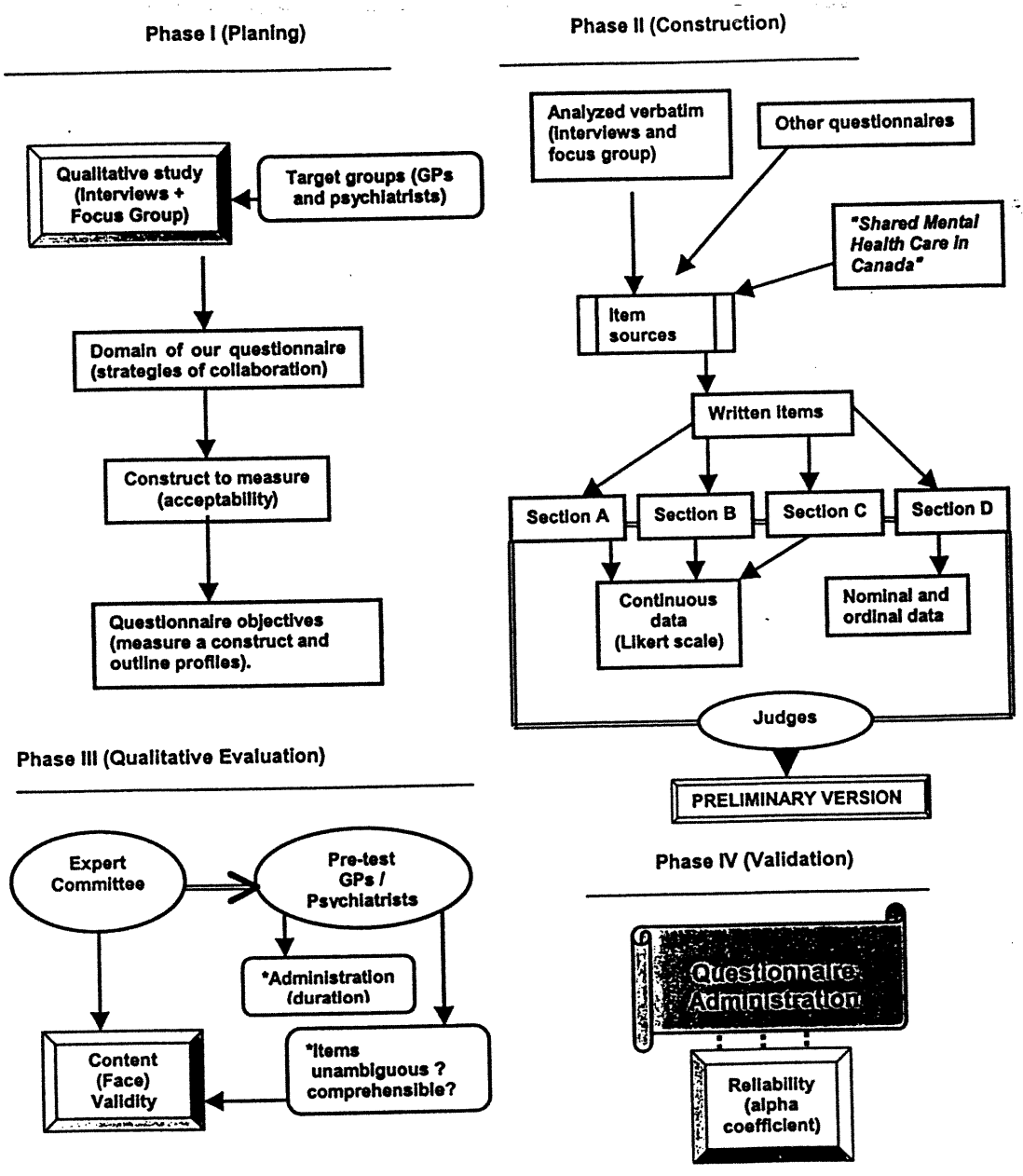
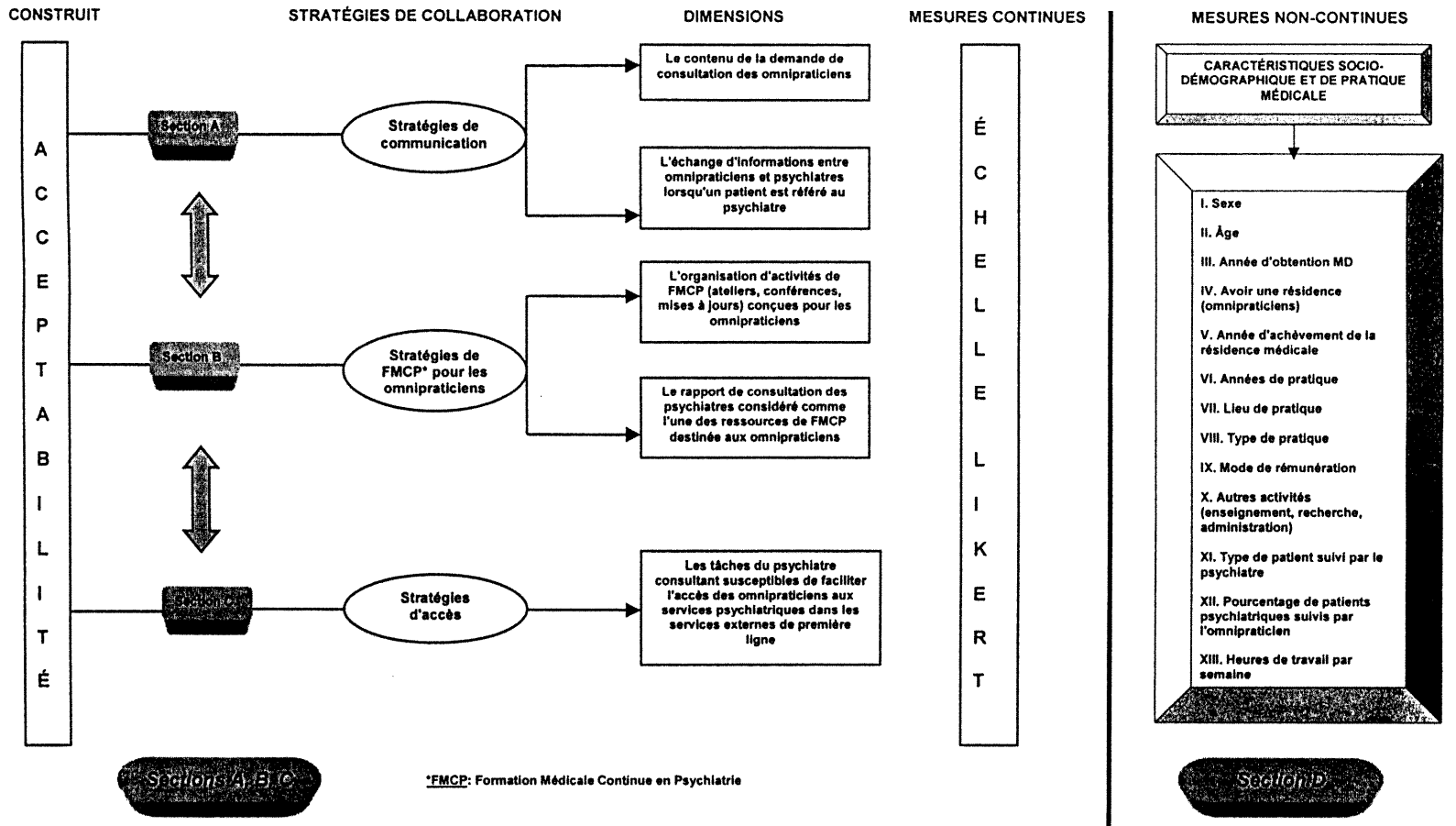


CHART OF THE STRUCTURE OF THE QUESTIONNAIRE



*FMCP: Formation Médicale Continue en Psychiatrie

QUESTIONNAIRE

GPs' and psychiatrists' versions

GPs' VERSION

STRATÉGIES DE COLLABORATION ENTRE MÉDECINS PSYCHIATRES ET MÉDECINS GÉNÉRALISTES

Ce questionnaire permet de mesurer votre degré d'accord ou de désaccord à l'égard des stratégies de collaboration entre médecins psychiatres et médecins généralistes. Il vous faudra environ quinze minutes pour le compléter. De plus, il est à noter que, pour les besoins spécifiques de ce questionnaire, la première ligne se définit comme suit: le médecin généraliste œuvrant en CLSC, en cabinet privé ou en unité de médecine générale.

Veuillez prendre note que toutes les informations recueillies, à partir de ce questionnaire, seront traitées de façon confidentielle. En outre, l'anonymat de tous les répondants sera maintenu. Le numéro d'identification attribué à chaque questionnaire sert uniquement à l'acheminement du courrier. Ainsi, nous serons en mesure d'enlever votre nom de notre liste d'envoi, dès la réception de votre questionnaire dûment complété.

Les résultats de cette étude seront disponibles aux membres des associations médicales, des départements de médecine générale et de psychiatrie, aux planificateurs de la santé, ainsi qu'à n'importe quel médecin intéressé à cette thématique. De plus, nous vous offrons la possibilité de recevoir un résumé des résultats en inscrivant la formule "demande d'une copie des résultats" au verso de l'enveloppe affranchie. Veuillez écrire votre nom et adresse en lettre moulée. S'il vous plaît, **n'inscrivez pas** ces informations dans le questionnaire.

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STRATÉGIES DE COLLABORATION ENTRE MÉDECINS PSYCHIATRES ET MÉDECINS GÉNÉRALISTES

(VERSION MÉDECIN GÉNÉRALISTE)

VEUILLEZ RÉPONDRE À CHACUN DES ITEMS, SELON LES CONSIGNES CI-DESSOUS. IL N'Y A PAS DE BONNES OU MAUVAISES RÉPONSES.

I. Ce questionnaire sera décodé par un lecteur optique. Il est donc important de noircir les cercles ainsi:

Noircir comme ceci :	●
Pas comme ceci :	⊗ ⊘

II. Veuillez noircir **un seul cercle** de l'échelle suivante:

Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord

SECTION A: STRATÉGIES DE COMMUNICATION	Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord
1. Dans sa demande de consultation en psychiatrie, le généraliste devrait...					
1.1. mentionner son impression diagnostique au sujet du patient référé.	O	O	O	O	O 1
1.2. décrire les essais thérapeutiques antérieurs.	O	O	O	O	O 2
1.3. fournir une évaluation des risques de suicide ou d'homicide chez le patient référé, s'il y a lieu.	O	O	O	O	O 3
1.4. inclure les antécédents médicaux pertinents du patient référé.	O	O	O	O	O 4
1.5. inclure les antécédents psychiatriques du patient référé, s'il y a lieu.	O	O	O	O	O 5
1.6. préciser si l'évaluation psychiatrique d'un patient référé est motivée par un arrêt ou un retour au travail.	O	O	O	O	O 6
1.7. indiquer les contacts que le patient référé aurait déjà eus avec des professionnels non médicaux spécialisés en santé mentale.	O	O	O	O	O 7
1.8. définir ses attentes et besoins quant à l'évaluation psychiatrique.	O	O	O	O	O 8

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SECTION A: STRATÉGIES DE COMMUNICATION (suite)

	Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord
2. Dans son rapport de consultation, le psychiatre devrait...					
2.1. insister sur les dimensions diagnostiques et thérapeutiques de l'évaluation clinique du patient référé.	O	O	O	O	O
					9
2.2. proposer au généraliste un plan de traitement séquentiel pour le patient référé, advenant un échec thérapeutique avec le premier choix de traitement.	O	O	O	O	O
					10
3. Le psychiatre devrait envoyer au généraliste un rapport complet de consultation, pour chaque patient référé.	O	O	O	O	O
					11

*Si vous êtes d'accord avec l'énoncé ci-dessus, veuillez noircir **une** des options suivantes pour indiquer le délai pour l'envoi du rapport de consultation:

- O Une semaine suivant la consultation
- O Deux semaines suivant la consultation
- O Trois semaines suivant la consultation
- O Quatre semaines suivant la consultation
- O Plus de quatre semaines suivant la consultation

12

	Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord
4. Il serait recommandé que le psychiatre informe le généraliste, dans les quarante-huit heures suivant l'évaluation du patient référé, des mesures thérapeutiques à prendre.	O	O	O	O	O
					13
5. Il serait utile de concevoir une carte de soins sur laquelle psychiatres et généralistes échangeraient des informations au sujet de la pharmacothérapie d'un patient suivi conjointement.	O	O	O	O	O
					14
6. Les psychiatres et les généralistes devraient échanger des notes écrites à propos de l'évolution des patients qu'ils suivent conjointement, lors d'apparition d'éléments nouveaux dans le suivi (crise, nouveau diagnostic, entre autres).	O	O	O	O	O
					15

SECTION A: STRATÉGIES DE COMMUNICATION (suite)	**Fortement en désaccord**	**Plutôt en désaccord**	**Je ne sais pas**	**Plutôt d'accord**	**Fortement d'accord**	
7. L'échange d'informations cliniques entre psychiatres et généralistes, à propos d'un patient partagé...						
7.1. devrait avoir lieu avec le consentement du patient.	O	O	O	O	O	16
7.2. pourrait avoir lieu sans le consentement du patient dans une situation d'urgence.	O	O	O	O	O	17
8. Le psychiatre pourrait fournir un horaire préétabli de sa disponibilité, pour répondre aux appels des généralistes à l'égard des problèmes de santé mentale.	O	O	O	O	O	18
9. Le psychiatre devrait communiquer, par téléphone, avec le généraliste en cas d'urgence à la suite d'une évaluation.	O	O	O	O	O	19
10. Lors de la référence d'un patient en psychiatrie, il serait souhaitable que le généraliste puisse parler, par téléphone, directement au psychiatre, pour fournir ou obtenir des informations médicales pertinentes au dossier du patient.	O	O	O	O	O	20
11. Le généraliste devrait accepter d'échanger, par téléphone, avec des professionnels autres que des psychiatres, au sujet d'un patient référé à un service psychiatrique.	O	O	O	O	O	21
12. L'échange efficace d'informations entre généralistes et psychiatres pourrait avoir lieu plus facilement...						
12.1. Par écrit.	O	O	O	O	O	22
12.2. Par téléphone.	O	O	O	O	O	23

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SECTION B: STRATÉGIES DE FORMATION MÉDICALE CONTINUE	Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord
13. Les activités de formation médicale continue en psychiatrie, destinées aux généralistes...					
13.1. constituent une excellente façon de rapprocher psychiatres et généralistes.	O	O	O	O	O 24
13.2. pourraient être organisées conjointement par des psychiatres et des généralistes.	O	O	O	O	O 25
***Ces activités devraient être financées par...**					
Des hôpitaux.	O	O	O	O	O 26
Des fondations à buts non lucratifs.	O	O	O	O	O 27
Les régies régionales.	O	O	O	O	O 28
Les compagnies pharmaceutiques.	O	O	O	O	O 29
14. Les ateliers interactifs de formation médicale continue en psychiatrie, offerts aux généralistes pourraient...					
14.1. inclure des discussions de cas.	O	O	O	O	O 30
14.2. inclure la remise de documents pertinents.	O	O	O	O	O 31
14.3. prendre la forme d'une présentation, où un psychiatre, à titre d'expert, présenterait un thème propre à la psychiatrie de première ligne, et où un généraliste modérateur, à la fin de la présentation du psychiatre, donnerait son opinion.	O	O	O	O	O 32
15. Les conférences en psychiatrie, destinées aux généralistes devraient favoriser des échanges libres entre le groupe de généralistes qui assiste à une conférence et le psychiatre expert dirigeant celle-ci.	O	O	O	O	O 33
16. Le rapport de consultation psychiatrique pourrait être une excellente source de formation médicale continue en psychiatrie.	O	O	O	O	O 34
17. À fréquence déterminée, des mises à jour d'une demi-journée pourraient se dérouler, au cours desquelles les psychiatres informeraient les généralistes des nouveautés et développements en psychiatrie.	O	O	O	O	O 35

SECTION B: STRATÉGIES DE FORMATION MÉDICALE CONTINUE (suite)	**Fortement en désaccord**	**Plutôt en désaccord**	**Je ne sais pas**	**Plutôt d'accord**	**Fortement d'accord**
18. Les formules suivantes constituent de sources importantes de formation médicale continue en psychiatrie pour les généralistes:					
18.1. Atelier interactif;	O	O	O	O	O 36
18.2. Conférence;	O	O	O	O	O 37
18.3. Rapport de consultation en psychiatrie;	O	O	O	O	O 38
18.4. Mise à jour;	O	O	O	O	O 38a
18.5. L'échange sur place avec un psychiatre, lors d'une consultation;	O	O	O	O	O 39
18.6. L'échange par téléphone avec un psychiatre, lors d'une consultation.	O	O	O	O	O 40

SECTION C: STRATÉGIES D'ACCÈS AUX PSYCHIATRES	**Fortement en désaccord**	**Plutôt en désaccord**	**Je ne sais pas**	**Plutôt d'accord**	**Fortement d'accord**
19. Chaque département clinique de psychiatrie devrait prévoir le poste d'un psychiatre ayant pour fonction de participer à des activités de soins partagés en santé mentale avec des généralistes.	O	O	O	O	O 41
20. Un psychiatre devrait être jumelé à plusieurs généralistes.	O	O	O	O	O 42
21. Le secteur, couvert par un psychiatre œuvrant auprès de la première ligne, devrait être défini à partir des adresses des généralistes exerçant dans son secteur psychiatrique plutôt que des adresses des patients.	O	O	O	O	O 43
22. Les psychiatres pourraient rendre visite aux CLSC ou aux cliniques de médecine générale.	O	O	O	O	O 44

*Si vous êtes d'accord avec l'énoncé ci-dessus, veuillez noircir <u>une</u> des options suivantes pour indiquer la fréquence des visites:

O Une fois par semaine

O Une fois chaque deux semaines

O Une fois chaque trois semaines

O Une fois chaque quatre semaines

45

SECTION C: STRATÉGIES D'ACCÈS AUX PSYCHIATRES (suite)	Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord
23. Il devrait y avoir un psychiatre consultant sur place...					
23.1. dans les CLSC.	O	O	O	O	O 46
23.2. dans les cliniques de médecine générale.	O	O	O	O	O 47
24. Les psychiatres consultants auprès de la première ligne devraient...					
24.1. être disponibles au besoin pour compléter des évaluations conjointes avec les généralistes.	O	O	O	O	O 48
24.2. être disponibles pour faire des évaluations à domicile, selon les cas.	O	O	O	O	O 49
24.3. offrir un service de consultation spécifique pour soutenir les généralistes dans le suivi de leurs patients en arrêt de travail ou de retour au travail.	O	O	O	O	O 50
24.4. mener des activités éducatives dans le cabinet des généralistes.	O	O	O	O	O 51
24.5. offrir une supervision clinique aux généralistes, en ce qui a trait à la relation médecin-malade.	O	O	O	O	O 52
24.6. offrir une supervision clinique aux généralistes, au sujet de la médication.	O	O	O	O	O 53

Veuillez répondre aux questions de la SECTION D aux pages suivantes

SECTION D: PROFIL DE PRATIQUE - MÉDECINS GÉNÉRALISTES

IMPORTANT: ce questionnaire sera décodé par un lecteur optique. Il est donc important d'inscrire vos réponses dans les cases de la façon suivante:

0 1 2 3 4 5 6 7 8 9

Il est également important de noircir les cercles ainsi:

Noircir comme ceci :	●
Pas comme ceci :	⊠ Ø

25. Sexe O Féminin O Masculin 54

26. Âge ☐☐ ans 55

27. En quelle année avez-vous obtenu votre MD ? ☐☐☐☐ 56

28. Avez-vous complété une résidence en médecine familiale ? O Oui O Non 57

Si Oui,

En quelle année avez-vous terminé votre résidence ? ☐☐☐☐ 57a

29. Depuis combien d'années exercez-vous la médecine générale ? ☐☐ années 58

30. Dans quel établissement se déroulent **la plupart** de vos heures de travail ?

- O CLSC
- O Cabinet privé
- O Hôpital général
- O Hôpital psychiatrique
- O Urgence psychiatrique
- O Clinique externe de psychiatrie
- O Autre _____ 59

31. Dans cet établissement, quel type de pratique exercez-vous ?

- O Solo // Avec rendez-vous
- O Solo // Sans rendez-vous
- O Solo // Avec et sans rendez-vous
- O En groupe // Avec rendez-vous
- O En groupe // Sans rendez-vous
- O En groupe // Avec et sans rendez-vous 60

SECTION D: PROFIL DE PRATIQUE - MÉDECINS GÉNÉRALISTES

32. Dans cet établissement, comment êtes-vous rémunéré (forme principale de rémunération) ? Vous pouvez noircir plus qu'un cercle, si nécessaire.

- O À l'acte
- O Salaire
- O Tarif horaire
- O Mixte (forfait)
- O Privé (hors régie)
- O Autre _____ 61

33. Veuillez indiquer, en termes de pourcentage, la distribution de vos activités professionnelles.

Soins de patients

- dans un hôpital de courte durée		% 62
- dans un CHSLD		% 63
- dans un CLSC		% 64
- dans un centre de réadaptation		% 65
- au cabinet privé		% 66
- à domicile		% 67
- à l'hôpital psychiatrique (interne)		% 68
- à la clinique externe de psychiatrie		% 69
Enseignement (exclure le temps consacré aux soins des patients)		% 70
Recherche (exclure le temps consacré aux soins des patients)		% 71
Autres activités		% 72
Spécifiez _____		
TOTAL	1 0 0	%

34. Quelle proportion des patients que vous suivez présentent des problèmes de santé mentale? ____ % 73

35. Veuillez indiquer le nombre total de vos heures de travail par semaine: ____ heures par semaine 74

PSYCHIATRISTS' VERSION

STRATÉGIES DE COLLABORATION ENTRE MÉDECINS PSYCHIATRES ET MÉDECINS GÉNÉRALISTES

Ce questionnaire permet de mesurer votre degré d'accord ou de désaccord à l'égard des stratégies de collaboration entre médecins psychiatres et médecins généralistes. Il vous faudra environ quinze minutes pour le compléter. De plus, il est à noter que, pour les besoins spécifiques de ce questionnaire, la première ligne se définit comme suit: le médecin généraliste œuvrant en CLSC, en cabinet privé ou en unité de médecine générale.

Veuillez prendre note que toutes les informations recueillies, à partir de ce questionnaire, seront traitées de façon confidentielle. En outre, l'anonymat de tous les répondants sera maintenu. Le numéro d'identification attribué à chaque questionnaire sert uniquement à l'acheminement du courrier. Ainsi, nous serons en mesure d'enlever votre nom de notre liste d'envoi, dès la réception de votre questionnaire dûment complété.

Les résultats de cette étude seront disponibles aux membres des associations médicales, des départements de médecine générale et de psychiatrie, aux planificateurs de la santé, ainsi qu'à n'importe quel médecin intéressé à cette thématique. De plus, nous vous offrons la possibilité de recevoir un résumé des résultats en inscrivant la formule "demande d'une copie des résultats" au verso de l'enveloppe affranchie. Veuillez écrire votre nom et adresse en lettre moulée. S'il vous plaît, **n'inscrivez pas** ces informations dans le questionnaire.

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STRATÉGIES DE COLLABORATION ENTRE MÉDECINS PSYCHIATRES ET MÉDECINS GÉNÉRALISTES

(VERSION MÉDECIN PSYCHIATRE)

VEUILLEZ RÉPONDRE À CHACUN DES ITEMS, SELON LES CONSIGNES CI-DESSOUS. IL N'Y A PAS DE BONNES OU MAUVAISES RÉPONSES.

I. Ce questionnaire sera décodé par un lecteur optique. Il est donc important de noircir les cercles ainsi:

Noircir comme ceci :	●
Pas comme ceci :	⊠ ⊘

II. Veuillez noircir <u>un seul cercle</u> de l'échelle suivante:

Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord
○	○	○	○	○

<u>SECTION A:</u> STRATÉGIES DE COMMUNICATION	Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord	
1. Dans sa demande de consultation en psychiatrie, le généraliste devrait...						
1.1. mentionner son impression diagnostique au sujet du patient référé.	○	○	○	○	○	1
1.2. décrire les essais thérapeutiques antérieurs.	○	○	○	○	○	2
1.3. fournir une évaluation des risques de suicide ou d'homicide chez le patient référé, s'il y a lieu.	○	○	○	○	○	3
1.4. inclure les antécédents médicaux pertinents du patient référé.	○	○	○	○	○	4
1.5. inclure les antécédents psychiatriques du patient référé, s'il y a lieu.	○	○	○	○	○	5
1.6. préciser si l'évaluation psychiatrique d'un patient référé est motivée par un arrêt ou un retour au travail.	○	○	○	○	○	6
1.7. indiquer les contacts que le patient référé aurait déjà eus avec des professionnels non médicaux spécialisés en santé mentale.	○	○	○	○	○	7
1.8. définir ses attentes et besoins quant à l'évaluation psychiatrique.	○	○	○	○	○	8

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SECTION A: STRATÉGIES DE COMMUNICATION (suite)	Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord
2. Dans son rapport de consultation, le psychiatre devrait...					
2.1. insister sur les dimensions diagnostiques et thérapeutiques de l'évaluation clinique du patient référé.	O	O	O	O	O 9
2.2. proposer au généraliste un plan de traitement séquentiel pour le patient référé, advenant un échec thérapeutique avec le premier choix de traitement.	O	O	O	O	O 10
3. Le psychiatre devrait envoyer au généraliste un rapport complet de consultation, pour chaque patient référé.	O	O	O	O	O 11
*Si vous êtes d'accord avec l'énoncé ci-dessus, veuillez noircir **une** des options suivantes pour indiquer le délai pour l'envoi du rapport de consultation:	O Une semaine suivant la consultation O Deux semaines suivant la consultation O Trois semaines suivant la consultation O Quatre semaines suivant la consultation O Plus de quatre semaines suivant la consultation 12				
	Fortement en désaccord	**Plutôt en désaccord**	**Je ne sais pas**	**Plutôt d'accord**	**Fortement d'accord**
4. Il serait recommandé que le psychiatre informe le généraliste, dans les quarante-huit heures suivant l'évaluation du patient référé, des mesures thérapeutiques à prendre.	O	O	O	O	O 13
5. Il serait utile de concevoir une carte de soins sur laquelle psychiatres et généralistes échangeraient des informations au sujet de la pharmacothérapie d'un patient suivi conjointement.	O	O	O	O	O 14
6. Les psychiatres et les généralistes devraient échanger des notes écrites à propos de l'évolution des patients qu'ils suivent conjointement, lors d'apparition d'éléments nouveaux dans le suivi (crise, nouveau diagnostic, entre autres).	O	O	O	O	O 15

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SECTION A: STRATÉGIES DE COMMUNICATION (suite)	Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord
7. L'échange d'informations cliniques entre psychiatres et généralistes, à propos d'un patient partagé...					
7.1. devrait avoir lieu avec le consentement du patient.	O	O	O	O	O 16
7.2. pourrait avoir lieu sans le consentement du patient dans une situation d'urgence.	O	O	O	O	O 17
8. Le psychiatre pourrait fournir un horaire préétabli de sa disponibilité, pour répondre aux appels des généralistes à l'égard des problèmes de santé mentale.	O	O	O	O	O 18
9. Le psychiatre devrait communiquer, par téléphone, avec le généraliste en cas d'urgence à la suite d'une évaluation.	O	O	O	O	O 19
10. Lors de la référence d'un patient en psychiatrie, il serait souhaitable que le généraliste puisse parler, par téléphone, directement au psychiatre, pour fournir ou obtenir des informations médicales pertinentes au dossier du patient.	O	O	O	O	O 20
11. Le généraliste devrait accepter d'échanger, par téléphone, avec des professionnels autres que des psychiatres, au sujet d'un patient référé à un service psychiatrique.	O	O	O	O	O 21
12. L'échange efficace d'informations entre généralistes et psychiatres pourrait avoir lieu plus facilement...					
12.1. Par écrit.	O	O	O	O	O 22
12.2. Par téléphone.	O	O	O	O	O 23

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SECTION B: STRATÉGIES DE FORMATION MÉDICALE CONTINUE	Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord
13. Les activités de formation médicale continue en psychiatrie, destinées aux généralistes...					
13.1. constituent une excellente façon de rapprocher psychiatres et généralistes.	O	O	O	O	O 24
13.2. pourraient être organisées conjointement par des psychiatres et des généralistes.	O	O	O	O	O 25
***Ces activités devraient être financées par...**					
Des hôpitaux.	O	O	O	O	O 26
Des fondations à buts non lucratifs.	O	O	O	O	O 27
Les régies régionales.	O	O	O	O	O 28
Les compagnies pharmaceutiques.	O	O	O	O	O 29
14. Les ateliers interactifs de formation médicale continue en psychiatrie, offerts aux généralistes pourraient...					
14.1. inclure des discussions de cas.	O	O	O	O	O 30
14.2. inclure la remise de documents pertinents.	O	O	O	O	O 31
14.3. prendre la forme d'une présentation, où un psychiatre, à titre d'expert, présenterait un thème propre à la psychiatrie de première ligne, et où un généraliste modérateur, à la fin de la présentation du psychiatre, donnerait son opinion.	O	O	O	O	O 32
15. Les conférences en psychiatrie, destinées aux généralistes devraient favoriser des échanges libres entre le groupe de généralistes qui assiste à une conférence et le psychiatre expert dirigeant celle-ci.	O	O	O	O	O 33
16. Le rapport de consultation psychiatrique pourrait être une excellente source de formation médicale continue en psychiatrie.	O	O	O	O	O 34
17. À fréquence déterminée, des mises à jour d'une demi-journée pourraient se dérouler, au cours desquelles les psychiatres informeraient les généralistes des nouveautés et développements en psychiatrie.	O	O	O	O	O 35

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SECTION B: STRATÉGIES DE FORMATION MÉDICALE CONTINUE (suite)	Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord
18. Les formules suivantes constituent de sources importantes de formation médicale continue en psychiatrie pour les généralistes:					
18.1. Atelier interactif;	O	O	O	O	O 36
18.2. Conférence;	O	O	O	O	O 37
18.3. Rapport de consultation en psychiatrie;	O	O	O	O	O 38
18.4. Mise à jour;	O	O	O	O	O 38a
18.5. L'échange sur place avec un psychiatre, lors d'une consultation;	O	O	O	O	O 39
18.6. L'échange par téléphone avec un psychiatre, lors d'une consultation.	O	O	O	O	O 40

SECTION C: STRATÉGIES D'ACCÈS AUX PSYCHIATRES	Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord
19. Chaque département clinique de psychiatrie devrait prévoir le poste d'un psychiatre ayant pour fonction de participer à des activités de soins partagés en santé mentale avec des généralistes.	O	O	O	O	O 41
20. Un psychiatre devrait être jumelé à plusieurs généralistes.	O	O	O	O	O 42
21. Le secteur, couvert par un psychiatre œuvrant auprès de la première ligne, devrait être défini à partir des adresses des généralistes exerçant dans son secteur psychiatrique plutôt que des adresses des patients.	O	O	O	O	O 43
22. Les psychiatres pourraient rendre visite aux CLSC ou aux cliniques de médecine générale.	O	O	O	O	O 44
*Si vous êtes d'accord avec l'énoncé ci-dessus, veuillez noircir une des options suivantes pour indiquer la fréquence des visites:	O Une fois par semaine O Une fois chaque deux semaines O Une fois chaque trois semaines O Une fois chaque quatre semaines				45

SECTION C: STRATÉGIES D'ACCÈS AUX PSYCHIATRES (suite)	Fortement en désaccord	Plutôt en désaccord	Je ne sais pas	Plutôt d'accord	Fortement d'accord
23. Il devrait y avoir un psychiatre consultant sur place...					
23.1. dans les CLSC.	O	O	O	O	O 46
23.2. dans les cliniques de médecine générale.	O	O	O	O	O 47
24. Les psychiatres consultants auprès de la première ligne devraient...					
24.1. être disponibles au besoin pour compléter des évaluations conjointes avec les généralistes.	O	O	O	O	O 48
24.2. être disponibles pour faire des évaluations à domicile, selon les cas.	O	O	O	O	O 49
24.3. offrir un service de consultation spécifique pour soutenir les généralistes dans le suivi de leurs patients en arrêt de travail ou de retour au travail.	O	O	O	O	O 50
24.4. mener des activités éducatives dans le cabinet des généralistes.	O	O	O	O	O 51
24.5. offrir une supervision clinique aux généralistes, en ce qui a trait à la relation médecin-malade.	O	O	O	O	O 52
24.6. offrir une supervision clinique aux généralistes, au sujet de la médication.	O	O	O	O	O 53

Veuillez répondre aux questions de la SECTION D aux pages suivantes ➡

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SECTION D: PROFIL DE PRATIQUE - MÉDECINS PSYCHIATRES

IMPORTANT: ce questionnaire sera décodé par un lecteur optique. Il est donc important d'inscrire vos réponses dans les cases de la façon suivante:

0	1	2	3	4	5	6	7	8	9

Il est également important de noircir les cercles ainsi:

Noircir comme ceci : ●
Pas comme ceci : ⊠ ⊘

25. Sexe O Féminin O Masculin 54

26. Âge ☐☐ ans 55

27. En quelle année avez-vous obtenu votre MD ? ☐☐☐☐ 56

28. En quelle année avez-vous achevé votre formation en psychiatrie ? ☐☐☐☐ 57

29. Depuis combien d'années exercez-vous la psychiatrie ? ☐☐ années 58

30. Dans quel établissement se déroulent **la plupart** de vos heures de travail ?

O CLSC
O Cabinet privé
O Hôpital général
O Hôpital psychiatrique
O Urgence psychiatrique
O Clinique externe de psychiatrie
O Autre _____ 59

31. Dans cet établissement, quel type de pratique exercez-vous ?

O Solo // Avec rendez-vous
O Solo // Sans rendez-vous
O Solo // Avec et sans rendez-vous
O En groupe // Avec rendez-vous
O En groupe // Sans rendez-vous
O En groupe // Avec et sans rendez-vous 60

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SECTION D: PROFIL DE PRATIQUE - MÉDECINS PSYCHIATRES

32. Dans cet établissement, comment êtes-vous rémunéré (forme principale de rémunération) ? Vous pouvez noircir plus qu'un cercle, si nécessaire.

- O À l'acte
- O Salaire
- O Tarif horaire
- O Mixte (forfait)
- O Privé (hors régie)
- O Autre _____ 61

33. Veuillez indiquer, en termes de pourcentage, la distribution de vos activités professionnelles.

Soins de patients

- dans un hôpital de courte durée		% 62
- dans un CHSLD		% 63
- dans un CLSC		% 64
- dans un centre de réadaptation		% 65
- au cabinet privé		% 66
- à domicile		% 67
- à l'hôpital psychiatrique (interne)		% 68
- à la clinique externe de psychiatrie		% 69
Enseignement (exclure le temps consacré aux soins des patients)		% 70
Recherche (exclure le temps consacré aux soins des patients)		% 71
Autres activités		% 72
Spécifiez _____		
TOTAL	1 0 0	%

34. Considérant l'âge de vos patients, quel type de patient suivez-vous principalement ?

O Adulte O Enfant // Adolescent O Personne âgée 73

35. Veuillez indiquer le nombre total de vos heures de travail par semaine: _____ heures par semaine 74

COVER LETTER AND REMINDERS OF THE QUESTIONNAIRE

COVER LETTER (first copy of the questionnaire)

COLLÈGE DES MÉDECINS
DU QUÉBEC

Le 18 octobre 2000

Docteur Aline Bédard
Clinique Médicale Familiale de l'Est,
1234, rue Ontario Est, bureau 567
Montréal (Québec) H1W 1R7

Docteur,

Au cours des dernières années, le système de soins de santé a connu des transformations importantes. Des soins, jadis offerts dans le milieu hospitalier, ont été transférés vers les services externes de première ligne, tout en apportant des responsabilités additionnelles aux médecins spécialistes et aux médecins généralistes. Dans le champ de la santé mentale, nous savons depuis longtemps que les médecins généralistes doivent composer avec une bonne partie des patients soufrant de troubles mentaux. Par contre, plusieurs études ont déjà confirmé qu'il existe peu de collaboration entre ces médecins et les médecins psychiatres. Cette collaboration peut permettre aux premiers de mieux s'acquitter de leurs tâches en santé mentale. Des associations professionnelles telles que le Collège des médecins du Québec, le Collège des médecins de famille du Canada et l'Association des psychiatres du Canada ont formulé récemment des recommandations à ce sujet. Toutefois, l'opinion des médecins cliniciens à l'égard de cette collaboration reste encore à connaître.

Dans ce contexte, le Collège des médecins du Québec appuie et participe à une enquête développée par des chercheurs du Centre de Recherche Fernand-Séguin, affilié à l'Université de Montréal. La Régie Régionale de la Santé et des Services Sociaux de Montréal Centre appuie également cette enquête. L'objectif principal de l'enquête est de sonder l'opinion des médecins généralistes et des médecins psychiatres, à propos des stratégies susceptibles d'améliorer la collaboration entre ces médecins.

Vous êtes l'un des médecins à qui nous demandons de bien vouloir compléter le questionnaire annexé à cette lettre. Votre nom a été choisi, au hasard, à partir d'une liste de tous les médecins généralistes et de tous les médecins psychiatres qui travaillent dans le secteur francophone de l'île de Montréal. Pour que les résultats de cette étude représentent véritablement la pensée des médecins consultés, il est très important que chaque questionnaire soit complété soigneusement et retourné en utilisant l'enveloppe affranchie que nous joignons avec le questionnaire. Plus le taux de réponse sera élevé, plus l'opinion des médecins pourra être considérée dans l'organisation des modèles de collaboration.

Si vous avez des questions à nous poser, veuillez nous contacter par courrier électronique, rlucena@ssss.gouv.qc.ca, ou par téléphone, en composant le [redacted]

Nous vous remercions à l'avance pour votre participation.

Veuillez agréer, Docteur, nos sentiments les meilleurs.

Yves Lamontagne, MD
Président du Collège des Médecins du Québec

Ricardo J. M. Lucena, MD, M.sc.

Alain Lesage, MD, M.phil.

Coordonnateurs du projet

REMINDER 1 (Thank you note)

COLLÈGE DES MÉDECINS
DU QUÉBEC

Le 25 octobre 2000

Docteur Aline Bédard
Clinique Médicale Familiale de l'Est,
1234, rue Ontario Est, bureau 567
Montréal (Québec) H1W 1R7

Docteur,

La semaine passée, nous vous avons envoyé un questionnaire par la poste. Ce dernier vise à sonder votre opinion à propos des stratégies susceptibles d'améliorer la collaboration entre médecins généralistes et médecins psychiatres. Votre nom a été choisi, au hasard, à partir d'une liste de tous les médecins généralistes et de tous les médecins psychiatres francophones qui pratiquent à Montréal.

Si vous avez déjà retourné le questionnaire dûment complété, nous vous en remercions infiniment. Si non, nous vous prions de le faire dans les plus brefs délais. Nous vous rappelons l'importance de remplir ce questionnaire puisqu'il n'a été envoyé qu'à un petit échantillon, bien que représentatif, de médecins francophones pratiquant à Montréal. Alors, votre réponse est essentielle, pour que les résultats de cette enquête puissent vraiment représenter l'opinion des médecins.

Si pour une raison ou une autre, vous n'avez pas reçu le questionnaire, ou encore, si vous l'avez égaré, veuillez nous en faire part par téléphone en signalant le [redacted] Il nous fera plaisir de vous en faire parvenir une autre copie sous peu.

Nous vous remercions, une fois encore, de votre précieuse participation.

Veuillez agréer, Docteur, nos sentiments les meilleurs.

Yves Lamontagne, M.D.
Président du Collège des Médecins du Québec

Ricardo J. M. Lucena, M.D., M.sc.

Alain Lesage, M.D., M.phil.

Coordonnateurs du projet

REMINDER 2 (second copy of the questionnaire)

COLLÈGE DES MÉDECINS
DU QUÉBEC

Le 7 novembre 2000

Docteur Aline Bédard
Clinique Médicale Familiale de l'Est,
1234, rue Ontario Est, bureau 567
Montréal (Québec) H1W 1R7

Docteur,

Il y a environ trois semaines, nous vous avons envoyé une lettre dans laquelle nous vous invitions à exprimer votre opinion, dans un questionnaire, à l'égard des stratégies susceptibles d'améliorer la collaboration entre médecins généralistes et médecins psychiatres. Toutefois, à cette date, nous n'avons pas reçu votre questionnaire.

Nous conduisons cette enquête, parce que nous croyons à l'importance de considérer l'opinion des médecins cliniciens dans l'organisation des services santé dans lesquels ils sont impliqués. Ainsi, les modèles de collaboration entre généralistes et psychiatres ne seront plus seulement une abstraction théorique des planificateurs, mais, surtout, un ensemble de stratégies compatibles avec la réalité de la pratique médicale à Montréal.

Nous vous contactons à nouveau, dans le but de vous rappeler l'importance de votre réponse. Votre nom a été choisi aléatoirement pour cette enquête, à partir d'une liste (contenant plus de deux mille noms) de l'ensemble des médecins généralistes et des médecins psychiatres francophones qui pratiquent à Montréal. Dans ce processus d'échantillonnage, un groupe d'environ 400 médecins a été constitué au hasard. Il est donc essentiel que chaque médecin choisi nous retourne son questionnaire dûment complété, afin que les résultats de l'enquête représentent vraiment l'opinion de tous les médecins figurant dans la liste ci-dessus mentionnée.

Nous espérons que vous participerez à la réalisation de cette enquête en complétant le questionnaire et en le retournant prochainement. À cette fin, vous trouverez ci-joint, un exemplaire supplémentaire du questionnaire, ainsi qu'une enveloppe-réponse affranchie et pré-adressée. Votre participation est largement appréciée.

Si vous avez des questions, veuillez nous contacter par courrier électronique, [redacted] ou par téléphone, en signalant le [redacted]

Nous vous remercions, à l'avance, de votre précieuse participation.

Veuillez agréer, Docteur, nos sentiments les meilleurs.

Yves Lamontagne, M.D.
Président du Collège des Médecins du Québec

Ricardo J. M. Lucena, M.D., M.sc.

Alain Lesage, M.D., M.phil.

Coordonnateurs du projet

REMINDER 3 (third copy of the questionnaire)

COLLÈGE DES MÉDECINS
DU QUÉBEC

Le 21 novembre 2000

Docteur Aline Bédard
Clinique Médicale Familiale de l'Est,
1234, rue Ontario Est, bureau 567
Montréal (Québec) H1W 1R7

Docteur,

Nous vous écrivons cette lettre au sujet du questionnaire sur les stratégies susceptibles d'améliorer la collaboration entre médecins généralistes et médecins psychiatres. Nous n'avons toujours pas reçu votre questionnaire.

Nous avons déjà reçu un nombre significatif et encourageant de questionnaires complétés. Toutefois, la description précise de l'opinion des médecins à l'égard des stratégies de collaboration dépend de vous et des autres médecins qui participent à l'étude. Partant de l'expérience d'autres études, il se peut que vous fassiez partie d'un groupe de médecins qui perçoivent les stratégies de collaboration de façon considérablement différente des autres médecins qui ont déjà répondu. Nous reconnaissons, alors, l'importance d'avoir votre réponse, afin de décrire les différentes perspectives de l'opinion des médecins. Ainsi, les résultats de cette enquête pourront véritablement représenter l'opinion de l'ensemble des médecins généralistes et des médecins psychiatres francophones pratiquant à Montréal.

Les résultats de cette enquête pourront être d'importance particulière dans l'organisation des soins psychiatriques offerts dans les services de première ligne. Ils pourront permettre d'identifier des pistes d'action, pour améliorer la collaboration entre médecins généralistes et médecins psychiatres.

Nous espérons que vous participerez à la réalisation de cette enquête en complétant le questionnaire et en le retournant aussitôt que possible. À cette fin, vous trouverez ci-joint un exemplaire supplémentaire du questionnaire, ainsi qu'une enveloppe-réponse affranchie et pré-adressée. Votre participation contribuera énormément au succès de cette enquête.

Si vous avez des questions, veuillez nous contacter par courrier électronique, [redacted] ou par téléphone, en signalant le [redacted]

Nous vous remercions, à l'avance, de votre précieuse participation.

Veuillez agréer, Docteur, nos sentiments les meilleurs.

Yves Lamontagne, M.D.
Président du Collège des Médecins du Québec

Ricardo J. M. Lucena, M.D., M.sc.

Alain Lesage, M.D., M.phil.

Coordonnateurs du projet