Shaping the Mental Health Role of Family Physicians

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Family physicians have an important role in mental health care delivery. The psychiatry and family practice faculty at the University of Alabama College of Community Health Sciences recently examined the principal elements of this role and the ways in which these elements might best be incorporated into the teaching/learning process of a family medicine residency. Competency based approaches to curriculum development were chosen to permit flexibility of implementation and to allow involved physicians to participate in definition of their mental health roles. Methods used to construct the curriculum included interviews with graduated residents of the first four classes of the program, literature review, and a modified delphi/nominal group technique with family medicine and psychiatry faculty. The result was a competency based psychiatric curriculum supervised cooperatively by both psychiatry and family medicine faculty. This program is begun early in the residency, is integrated longitudinally into the rest of the residents' curriculum, and utilizes seminars, clinical experience, and liaison with a mental health team in the training design.

The report of the President's Commission on Mental Health[1] crystalized the growing consensus about the important roles that primary care physicians fill in mental health care delivery. The greater visibility of the mental health role of primary care physicians, particularly family physicians, has occurred for a number of reasons. Mental health care itself has changed radically in the past three decades. Active programs of inpatient treatment, the wide application of psychopharmacologic therapy, the emphasis on community based care, and right-to-treatment legislation have all contributed toward deinstitutionalization.[2] But community based services have not developed at a sufficient rate to allow this policy to be implemented fully. Only one third of community mental health centers planned have been opened.[3] It has been charged, furthermore, that community mental health centers have failed to serve the most seriously disabled deinstitutionalized patients.[4-6] In the midst of an apparent trend to close the state hospitals and "dump" chronically ill patients onto unprepared communities, the movement to integrate mental health services with primary health care delivery has gained momentum.[7]

The mental health needs of patients in general medical practices represent another dimension of the role of the family physician. Coleman and Patrick[8] suggested that the inclusion of mental health services as an integral component of primary health care offers the only feasible means to substantially improve mental health services for the population as a whole. This conclusion was amply

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supported by the report of the President's Commission on Mental Health,[1] in which it was reported that 15 percent of Americans, about 32 million people, suffer from mental disorder in a given year. Fully 60 percent of these were found to be receiving care exclusively in the primary care sector, four times as many as were being cared for in the specialty mental health sector. Studies of patients' attitudes about mental health services also support this role for the family physician.[9,10] Furthermore, even though only 2 percent of patient visits to nonpsychiatrists involve psychotherapy/therapeutic listening, because of their absolute numbers these physicians provide fully 46 percent of all psychotherapy/therapeutic listening offered to patients.[11] Hoeper et al[12] found that patients with mental disorder utilize general health services up to four times more than patients without mental disorder. It was concluded that funding for somatic medical care pays for a significant amount of mental health care not defined or reported as such.

With the high rate of mental disorder documented in primary care patients, psychiatric educational and service back-up will be increasingly needed if the thrust of primary care is to succeed. Although psychiatrists will be needed in increasing numbers for administrative, treatment, consultation/liaison, and educational functions,[13] there has been a steady decline in the absolute numbers and percentages of US graduates entering psychiatry. Neilsen[14] predicted that less than two percent of all medical students will be choosing a psychiatric career in 1980. The Health Professions Educational Assistance Act of 1976 severely restricted the number of foreign medical graduates who may enter the United States for residency training. The combination of a drop in the number of residents entering psychiatry and the numbers of foreign medical graduates allowed to enter the field will produce a severe shortage of needed psychiatric manpower in the next decade.[15]

Statewide Problems

Alabama has not been spared from a shortage or maldistribution of physicians. This largely rural state is 49th in physician/population ratio, and contains only one-third the national average of psychiatrists per 100,000 population. The state mental health system has been under federal court order for eight years[16] to conform to a detailed set of minimum constitutional standards for adequate treatment of the mentally ill. In 1980, it was found not in compliance with the order. With 64 percent of the population living on farms or in small towns, only 23 percent of the few available psychiatrists and 15 percent of physicians generally practice in these areas. Yet the indicators for high risk and increased need for mental health services, such as qualification for poverty designation, the percentage of aging, overcrowded housing, admission rates to state mental hospitals, suicide rates, and alcoholism rates, are most prevalent in rural areas.[17,18]

Undereducated poor people often lack the skill and knowledge to obtain even those services which are available. Per capita income in Alabama is only 80 percent of the national average, and approximately one third of the age group over 25 years has completed less than nine years of formal education.[19] These patients expect general physicians to help them with emotional disorders. The conclusion is inescapable that family medicine residents who will enter the underserved areas of Alabama must be trained to recognize, treat, and properly refer psychiatric patients.

The Family Medicine Residency at The University of Alabama College of Community Health Sciences was established in 1974 to prepare physicians to meet the health care needs of rural and underserved areas of the state. The residency had graduated four classes of family physicians when the psychiatry faculty undertook a complete evaluation of their share of the curriculum developed during the first seven years. Through this self-assessment, the faculty determined that additional experiences were needed if graduates of the program were to address the state's mental health needs and the mental health manpower shortage in the state and region. To develop efficient and effective psychiatric components for the family medicine residency, the psychiatry faculty in the college began a systematic redevelopment of their curriculum, focusing on the following questions:

1. What are the mental health elements of the professional role of family physicians?

2. How can these elements of professional roles best be incorporated in the teaching/learning process of the residency?

Methods

Early in the faculty's self-assessment process, it was decided that the optimal teaching/learning framework would be a competency based curriculum. Such an approach would provide the means for designing educational experiences around anticipated role functions and for permitting maximum flexibility in terms of time, resources, and logistics.[20] Because curriculum development in competency based education serves to define professional roles and elements of those roles, the process of development becomes as significant as its product. Of the many methods described for defining competencies,[21] three were chosen for use in this developmental process for the amount of information they could provide, for their compatibility with logistical and resource constraints, and for their applicability to the residency program: interviews of former residents in practice, a review of the literature, and a modified delphi/ nominal group technique.

Graduate Resident Interview

Representative residents from the first graduating classes met with college faculty to discuss their experiences in the residency and their professional experience since they began practice. They represented solo, family practice group, and multispecialty group practices. All the residents felt additional mental health experiences to be a priority for the resident curriculum. They were sensitive to mental health problems presented by their patients, but they felt unable to manage many of them adequately. Talking with patients and conducting psychotherapy for marital or divorce problems, sexual problems, psychophysiologic or hypochondriacal complaints were identified as significant problem areas. The statement of one graduate summarized these perceptions: "One of the hardest things I have to deal with is the middle-aged woman with a headache."

Review of the Literature

Efforts to increase the role of primary care physicians in mental health services must recognize the characteristics of their practices. They see an average of 140 to 180 patients in a work week that averages 60 hours per week.[22] Family physicians refer only 2.4 percent of their patients, hospitalize 2 percent, and provide counseling or psychotherapy in 18 percent of patient visits.[23] Priest[24] estimated the pragmatic general practitioner spends only seven minutes per psychotherapy patient visit and no more than one hour per month. Werkman et al[25] reported that family physicians see, in order of frequency, the following problems: marital problems, depression, hypochondriasis, alcoholism, chronic illness, and anxiety-tension states. Methods used to deal with emotional and psychiatric illness included the following, in decreasing order: advice and reassurance, tranquilizers, antidepressants, sedatives, and psychotherapy (according to Fowler H, Fabrega H: Michigan Academy of Family Physicians Psychiatric Survey done by Joseph V. Fisher, reporting unpublished data, 1972).

Another consideration emphasized by Fisher[26] is the need for the family physician to understand him/herself. A number of issues confront the family physician attempting to provide effective mental health care. First among these is his personal adjustment to living in an underserved, usually rural, area. It may be difficult for a middle class, urban trained professional to understand, much less fulfill, the therapeutic requirements of economically disadvantaged, geographically isolated, often ethnically and culturally distinct patients.[27]

The physician continues processes of personal maturation and professional identity development after beginning practice. Problems may arise within his marriage, with his children, or with substance abuse. He may develop an emotional disorder himself, for which he may be reluctant to seek help.[28] Any problem which occurs is further complicated by his high visibility in rural settings.

Finally, the physician providing psychotherapy/ therapeutic listening services to his patients needs to be aware of transference feelings and attitudes which occur between himself and the patient. An unprepared encounter with resistance or unexpected emotional reactions may be confusing, discouraging, or harmful. The physician may become acutely aware of his professional isolation and his need for mental health team and liaison relationships.[29,30] Traumatic experiences may render the family physician unwilling to diagnose discernible

mental disorders, to undertake needed therapeutic measures, or to refer thereafter. Or he may refer indiscriminately all patients suspected to have emotional disorders.

These data suggest practical issues in mental health care delivery and areas of important emphasis in mental health curricula for family practice residents. Family physicians need to be prepared for a broadly defined role in mental health care delivery and need to be trained to recognize and diagnose mental disorders, to manage certain patients, to recognize indications for referral to psychiatrists, to conduct psychotherapy with some patients, to prescribe psychotropic drugs appropriately, to utilize social intervention techniques, and to function as part of an interdisciplinary health team, maintaining professional liaison with other specialists.

Modified Delphi/Nominal Group Techniques

Family medicine and psychiatry faculty met together on a semi-weekly basis over the course of two months to arrive at a mutually defined set of psychiatric/mental health competencies for family physicians, to determine the requisite educational experiences necessary to meet these competencies in the residency, and to resolve necessary and appropriate logistical details. The process employed was similar to the delphi technique in that the same individuals constituted the respondent sample. The process began with a semi-structured solicitation/compilation of ideas which were subsequently categorized and refined through several iterations.[31] The process was also similar to the nominal group process in that the two faculty groups met together each time in the same location and were led in their deliberative process by a moderator.[31] Among the primary role functions and responsibilities mutually identified and described were management of long-term psychiatric patients and their families, crisis counseling, common problems of family life, and sexual counseling. As these functions and responsibilities were defined in the form of competencies, a variety of educational experiences and teaching/learning methodologies were established to accomplish them. Most of these activities centered on each resident seeing his/her family medicine patients requiring mental health care in the psychiatric suite in the model family practice clinic under the cooperative supervision of family practice and psychiatric faculty.

Results

The psychiatric curriculum resulting from this study is composed of a two-month block in the first year constituting part of the program's core curriculum. The purpose of this block is to establish a knowledge and skill base for the subsequent longitudinal competency based curriculum. In the first year, residents rotate in various clinical settings; service and didactic components of the curriculum are balanced to avoid overloading either one. Residents spend the first month focusing on the psychiatric dimension of the family medicine residency program. They see outpatients in the model outpatient suites and admit patients requiring hospitalization to the psychiatry unit of a community hospital. They participate actively in consultation/liaison activities with colleagues on other services and participate in a close working relationship with the community mental health center serving the catchment area.

During the second month, residents continue work in outpatient clinics, and they are assigned to a treatment team in an acute care unit of a psychiatric hospital where they manage a small number of seriously ill psychiatric patients under the teaching supervision of a faculty psychiatrist. The residents are expected to learn how to work with the treatment team in evaluation, treatment, and discharge planning on a daily basis and in team meetings. Their tour of duty includes four half-days in an alcoholism treatment unit and four half-days in a psychiatric hospital for children.

Following the completion of the first-year rotation, the resident is enrolled in a longitudinal, competency based curriculum directed jointly by psychiatry and family practice faculty, which focuses on mental health care delivery achieved principally in an ambulatory setting. Methods for attainment of these competencies are specified, but with considerable flexibility, to allow the resident to choose the timing, the supervision, and the treatment setting in each area. Competencies identified by the psychiatry and family medicine faculty include the following:

1. Manage long-term psychiatric patients and their families, including medication, individual counseling, and family counseling skills appropriate for family practice settings
2. Develop skill in crisis counseling techniques appropriate for family practice settings
3. Manage common sexual problems
4. Recognize normal and dysfunctional patterns of family life and techniques of family counseling appropriate to family practice
5. Manage common problems of family life, such as parenting, marital discord, family violence, and familial reactions to critical events such as illness, death, employment problems, and jealousy
6. Diagnose and manage psychiatric problems of children and adolescents
7. Understand relationships between psychosocial and physical aspects of disease
8. Manage psychiatric aspects of chronic disability commonly seen in family practice, including blindness, deafness, cerebral palsy, chronic brain syndrome, mental retardation, and any chronic illness
9. Prepare for and make at least one court appearance
10. Identify and manage common types of substance abuse seen in family practice, including alcoholism, sniffing of volatile substances, and drug abuse
11. Understand community mental health theory and practices and know the ways that a family physician can participate in community mental health
12. Recognize and manage the common syndromes and psychodynamics of occupational psychiatry, evaluation of psychiatric disability, and special management problems presented by these cases
13. Recognize and be able to manage mental health hazards of being a physician, including type and location of practice

The didactic element of this longitudinal curriculum consists of 20 sessions scheduled bimonthly in the third year. A series of 15 seminars related to the required competencies is conducted, along with case conferences or family dynamics conferences. A log of clinical and didactic experience directed toward achievement of the psychiatric competencies is kept by each resident and completed under the supervision of the Director of the Advanced Psychiatry Curriculum and the Director of the Family Medicine Residency.

Comment

This curriculum is designed with the expectation of considerable involvement by family physicians in mental health care delivery. Psychiatric education is begun early, before attitudes become fixed, to emphasize self-reliance and mental health problem solving skills, to make the learning experience longitudinal, and to integrate training in psychiatry into the rest of the residents' curriculum. Seminars, clinical experience, and liaison with a mental health team are all utilized in the training design. It is truly a conjoint effort, from planning through implementation and evaluation, of psychiatry and family practice faculty. This program will be studied over time to obtain needed data about its effectiveness as a model for teaching the mental health role of the family physician.

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References

1. Task Panel on Mental Health: Nature and scope of the problems. In Task Panel Reports Submitted to the President's Commission on Mental Health, vol 2. Government Printing Office, 1978
2. Committee on Psychiatry and the Community: The Chronic Mental Patient in the Community. New York, Group for Advancement of Psychiatry, 1978
3. Sharfstein SS: Will community mental health survive in the 1980s? Am J Psychiatry 135:1363, 1978
4. Hogarty GE: The plight of schizophrenics in modern treatment programs. Hosp Community Psychiatry 22:197, 1971
5. Fink PJ, Weinstein SP: Whatever happened to psychiatry? The deprofessionalization of community mental health centers. Am J Psychiatry 136:406, 1979
6. Goldman HH, Regier DA, Taube CA, et al: Commu-

nity mental health centers and the treatment of severe mental disorders. Am J Psychiatry 137:83, 1980

7. Borus J: Neighborhood health centers as providers of primary mental health care. N Engl J Med 295:140, 1976

8. Coleman JV, Patrick DL: Integrating mental health services into primary medical care. Med Care 16:654, 1976

9. Dohrenwend BT, Dohrenwend BD: Social Status and Psychological Disorder: A Causal Inquiry. New York, Wiley-Interscience, 1976

10. Fandetti DV, Gelfand DE: Attitudes toward symptoms and services in the ethnic family and neighborhood. Am J Orthopsychiatry 48:477, 1978

11. Report of the NIMH Group on Mental Health Training of Primary Care Providers. Department of Health, Education, and Welfare, National Institute of Mental Health, Alcohol, Drug Abuse, and Mental Health Administration (Rockville, MD). Government Printing Office, 1977

12. Hoeper EW, Nycz GR, Regier DA, et al: Diagnosis of mental disorder in adults and increased use of health services in four outpatient settings. Am J Psychiatry 137:207, 1980

13. Pardes H: Future needs for psychiatrists and other mental health personnel. Arch Gen Psychiatry 36:1401, 1979

14. Neilsen AC: The magnitude of declining psychiatry career choice. J Med Educ 54:632, 1979

15. Tucker GJ: The coming shortage of psychiatric manpower. Psychiatr Opin 15(5):9, 1977

16. Wyatt v. Stickney. 325 F Supp 781 (MD Ala 1971) and 344 F Supp 373 (MD Ala 1972)

17. Comprehensive Health Planning Administration: State Plan for Services to the Mentally Ill. Montgomery, Ala, Department of Mental Health, 1980

18. Comprehensive Health Planning Administration: Physician Manpower Study. Montgomery, Ala, Alabama Department of Public Health, 1977

19. Comprehensive Health Planning Administration: Statistical Manual: Community Mental Health-Retardation Programs. Montgomery, Ala, Alabama Department of Public Health, 1976

20. Knopke HJ: A framework for systematic educational planning. In Knopke HJ, Diekelmann NL (eds): Approaches to Teaching Primary Health Care. St. Louis, CV Mosby, in press

21. Segal AJ, Vanderschmidt H, Burglass R, et al: Systematic Course Design for the Health Field. New York, John Wiley, 1975

22. Geyman JP: The emerging profile of the residency trained family physician. J Fam Pract 11:717, 1980

23. Sivertson SE, Hansen RH, Shropshire RW: Family practices in Wisconsin: Implications for medical education and delivery of health care. Wis Med J 73(12):S-170, 1974

24. Priest RG: Psychotherapy in general practice: Expectations and experiences. Br J Med Psychol 43:288, 1970

25. Werkman SL, Mallory L, Harris J: Common psychiatric problems in family practice. Psychosomatics 17:119, 1976

26. Fisher JV: Psychiatry and the family physician. Psychosomatics 19:523, 1978

27. Gurian H: A decade in rural psychiatry. Hosp Community Psychiatry 22:56, 1971

28. Vaillant GE, Sobowale ND, McArthur C: Some psychological vulnerabilities of physicians. N Engl J Med 282: 365, 1972

29. Mazer M: People and Predicaments. Cambridge, Mass, Harvard University Press, 1976

30. Flax JW et al: Mental Health and Rural America: An Overview and Annotated Bibliography. Public Health Service, National Institute of Mental Health (Rockville, MD). DHEW publication No. (ADM) 78-753. Government Printing Office, 1979

31. Delbecq AL, Van de Ven AH, Gustafson DH: Group Techniques for Program Planning. Glenview, Ill, Scott, Foresman, 1975