Reversed Shared Care in Mental Health: Bringing Primary Physical Health Care to Psychiatric Patients

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ABSTRACT

Because of the significant comorbidity between mental and physical health conditions, it is imperative that access to high-quality primary physical health care be available for those with severe mental illnesses. Recognizing a gap in care, North York General Hospital (NYGH) developed and piloted a new service that built on the benefits of collaborative and shared care and the importance of co-location and service integration. In this reversed shared care clinic, access to primary physical health care was provided to patients of NYGH's mental health department. Descriptive findings demonstrate the implementation of the service and patient demographics.

Keywords: mental health, health care access, Reversed Shared Care, physical health care, comorbidity

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RÉSUMÉ

En raison de l'existence fréquente de problèmes concomitants de santé mentale et de santé physique, les personnes ayant une grave maladie mentale doivent avoir accès à des soins primaires de grande qualité en santé physique. Reconnaissant les lacunes à ce chapitre, l'Hôpital général de North York (NYGH) a élaboré et mis à l'essai un nouveau service qui misait sur les avantages des soins partagés et en collaboration et sur l'importance de l'intégration des services en un seul et même endroit. Dans le contexte de cette clinique de « soins partagés à l'inverse », le Département de santé mentale au NYGH a offert à ses patients et patientes l'accès à des soins primaires en santé physique. Les constatations descriptives mettent en évidence la mise en œuvre du service et les renseignements démographiques concernant les patients et patientes.

Mots clés: santé mentale, accès aux soins de santé, soins partagés à l'inverse (Reversed Shared Care), soins de santé physique, comorbidité

RELATIONSHIP BETWEEN PRIMARY CARE AND MENTAL HEALTH CARE

Shared Care Model

The need for modifications in the relationship between primary care physicians and mental health professionals has been a focus of interest in recent years. As a result of this interest, innovations in the delivery of mental health care in Canada have focused on the development of collaborative care programs between primary care physicians and mental health professionals. These innovations in shared care were originally defined as "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 in the course of a mental illness and the respective skills of the family physician and psychiatrist" (Kates et al., 1997, p. 9). Within Canada the movement toward shared care began in 1996 (Craven & Bland, 2002; Kates et al., 1997) and included the development of a number of initiatives such as the Collaborative Working Group between the College of Family Physicians and the Canadian Psychiatric Association (Craven & Kates, 2000) and the Canadian Collaborative Mental Health Initiative (CCMHI, 2006). The term *shared care* evolved to *collaborative mental health care* to include all members of the health care team including the person with mental illness and their families.

As Kates, Gagne, & Whyte (2008) note, "Over the last 10 years [since the movement began in 1996], shared or collaborative mental health care has moved from being a 'fringe' area of practice for a handful of providers across the country to one that is increasingly seen by provinces and health authorities as an integral part of their mental health care delivery systems" (p. 1). This focus on shared/collaborative care has now begun to move beyond the initial integration of a psychiatrist within a primary physical health care setting with the goal of improving the mental health care of those experiencing mental illness. The collaboration between primary care and mental health and addictions care continues to evolve to include inter-organizational collaboration between providers, health care leaders, and policy planners (for example, EnHANCE Ontario: Enabling Collaboration In Primary & Mental Health Care & Addictions Through Interprofessional Care & Education). Building on this integrated base, an additional component of shared and collaborative care is improving equitable access to physical health care for those with mental illnesses. It has become apparent

that more focus should be placed on improving access to high-quality general medical care for those with severe mental illnesses (Doey, Hines, Myslik, Leavey, & Seabrook, 2008; Kates et al., 2008) due to the significant comorbidity between mental and physical health conditions (e.g., Von Korff, Scott, & Gureje, 2009).

Comorbidity between Mental and Physical Health

In addition to the importance of those with mental health concerns receiving proper psychiatric care, these patients require adequate care for their physical health needs. Many mental health patients seen in psychiatric care have significant health conditions, because many mental health problems, particularly severe mental health problems such as psychiatric disorders, have been found to be associated with higher rates of physical health concerns, including neurodegenerative disorders (Nuti et al., 2004), cardiovascular diseases (Brown, Inskip, & Barraclough, 2000; Enger, Weatherby, Reynolds, Glasser, & Walker, 2004; Gilmour, 2008; Perlmutter, Frishman, & Feinstein, 2000; Wulsin & Singal, 2003), endocrine disorders (Anderson, Freedland, Clouse, & Lustman, 2001), and other chronic health conditions (Cizza, Ravn, Chrousos, & Gold, 2001; Cradock-O'Leary, Young, Yano, Wang, & Lee, 2002; Culpepper, 2009; Evans & Charney, 2003; Meyer, 2004; Moussavi et al., 2007; Roy-Byrne et al., 2008; Simon & Fischmann, 2005). Some studies, for example, find that poor physical health is a risk factor for depression, and a growing body of evidence suggests that depression is a factor in the development and course of many health conditions, including cancer, cardiovascular disease, diabetes, epilepsy, and stroke (Evans & Charney, 2003). These rates of comorbidity between mental and physical health differ by patient demographics, including mental health diagnosis, age, gender, race, and socioeconomic status (Gilmour, 2008; Haupt & Newcomer, 2001). Statistics Canada found that depression, for example, is associated with an increased risk of heart disease in women and did not find this association with men (Gilmour, 2008).

In addition, some medications (such as antipsychotics) prescribed to those with severe mental illnesses are associated with increased risks of health complications or the exacerbation of pre-existing medical problems (Balf, Stewart, Whitehead, & Baker, 2008; Pacher & Kecskemeti, 2004; Witchel, Hancox, & Nutt, 2003). To further demonstrate this, Reist and colleagues (2007) conducted a temporal analysis and found that the introduction of second-generation antipsychotic medications into the pharmaceutical market was associated with a drastic increase in the prevalence of obesity and diabetes in patients with schizophrenia. Mental health concerns are also associated with decreased adherence to medical treatments for chronic health conditions, leading to poorer health outcomes in diseases such as diabetes and heart disease (Meyer, Peteet, & Joseph, 2009; Prince et al., 2007).

The social context of some people living with a mental illness, such as poverty, inadequate housing, violence, and substance use, also has a strong impact on their physical health (Fisher & Baum, 2010; Oraka, King, & Callahan, 2010). People living with serious mental illnesses have an increased likelihood of experiencing poverty and living in substandard housing (Draine, Salzer, Culhane, & Hadley, 2002; Fryers, Melzer, & Jenkins, 2003). As a result of the numerous significant challenges associated with living in difficult socioeconomic situations, such as finding suitable accommodations, employment, or a meal, those with mental illnesses may find it difficult to engage in a healthy diet and lifestyle, resulting in increased health concerns (Beydoun & Wang, 2010; Cerin & Leslie, 2008). These poor lifestyle factors (e.g., lack of exercise, poor diet, and substance use), further compound the vulnerability people with mental illnesses have to health

conditions such as cardiovascular disease (Haupt & Newcomer, 2001; Hennekens, Hennekens, Hollar, & Casey, 2005; Robson & Gray, 2007). Based on this understanding, Meyer (2004) provided recommendations for monitoring patients with schizophrenia and comorbid metabolic syndromes, which included counselling on proper diet and exercise. Programs are also being developed that encourage positive lifestyle changes and identify physical health problems in those with severe mental illness (Ohlsen, Peacock, & Smith, 2005; Eldridge, Dawber, & Gray, 2011).

Lack of Primary Physical Care

In spite of the frequent comorbidity of severe health concerns and the resultant complications, people with mental illness often underutilize primary care services (Chwastiak, Rosenheck, & Kazis, 2008; Fleury, Grenier, Bamvita, & Caron, 2010), despite being high-frequency users of the health care system in the form of, for example, emergency departments (Byrne, Murphy, Plunkett, McGee, & Murray, 2003; Carr et al., 2003; Druss, 2007). Research shows that mental health patients use less primary health care than patients without mental health issues (Chwastiak et al., 2008), as fewer than half of those with a severe mental disorder consult their primary care physician (Fleury et al., 2010). This is further seen in surveys of psychiatric patients who report having substantively unmet medical needs and poor access to primary care (Levinson, Druss, Dombrowski, & Rosenheck, 2003).

In addition to a lack of access to primary care services, inequalities exist in the quality of general medical care provided to those with mental illness (Mitchell, Malone, & Doebbeling, 2009). In these studies, patients with mental illness received inadequate care for their medical conditions, including poorer care for their cardiovascular disease and diabetes, in contrast to non-psychiatric patients (Druss, Rohrbaugh, Levinson, & Rosenheck, 2001; Druss, Rosenheck, Desai, & Perlin, 2002; Frayne et al., 2005). In their recent review paper, Lord, Malone, and Mitchell (2010) found that preventive and screening health services received by mental health patients are often of poorer quality than those received by patients without a presenting mental health issue.

These findings underscore the limited involvement of the medical and primary physical health care system in these patients' care. This lack of access, inequality in care, and high rates of comorbidity can result in increased mortality (Cole, 2007; Felker, Yazel, & Short, 1996; Mitchell & Lord, 2010). In their systematic review, Mitchell & Lord (2010) found that deficits in the quality of cardiac care contributed to higher than expected mortality rates for individuals with schizophrenia. This lack of access to quality medical care, and the resultant increase in mortality, is particularly concerning given the high comorbidity rates between physical and mental health concerns.

Barriers to Primary Physical Care

Previous research has attempted to understand this lack of access and inequality of health care for those with mental illnesses. Potential barriers to physical health care include socio-demographic factors (e.g., sex), personal barriers (e.g., attitudes of patients, severity of mental health symptoms), care provider issues (e.g., attitude of providers, lack of relevant services, inadequate engagement with patients), and systemic barriers (e.g., availability of services; Byrne, 2008; Hughes et al., 2010; Kim et al., 2007; Swartz et al., 2003).

Similarly, Druss and Newcomer (2007) outlined geographical, financial, organizational, and cultural barriers that people with mental illness may experience when attempting to receive effective treatment.

Patients with mental illness may encounter barriers to effective health care at the provider level. Primary care providers often report a lack of training in working with those with mental illness and general inexperience with the mental health care system (Leigh, Stewart, & Mallios, 2006). Some Canadian provinces, such as British Columbia, have recognized the need for more training in mental health care for primary care physicians and are implementing major initiatives to develop their capacity via continuing medical education. Despite these attempts, those with mental illness are often faced with additional provider and systemic barriers to care as a result of discrimination and stigma (McNair, Highet, Hickie, & Davenport, 2002; Miller, Sheppard, Colenda, & Magen, 2001). For example, primary care physicians may be hesitant to accept a new patient into their practice if they know this patient has a severe mental health concern and/or substance abuse. They may also be less likely to engage the patient in the decision-making process because of the apparent cognitive effects of mental illness (Desai, Stefanovics, & Rosenheck, 2005).

A systemic barrier to accessing primary care is service fragmentation, where primary health care and mental health care services are provided in separate locations without coordination between these different locations and services (Drury, 2003). This segmentation has been described as the "split care model" (Ungar & Hoffman, 1998). The split care model does not adequately address the important social determinates of health (Kidd & McKenzie, 2011) and leads to poor communication between mental health professionals and primary care physicians (Bray & Rogers, 1995) This is of particular concern because poor communication between these two provider groups is a key barrier to adequate assessment and management of physical health problems in people with mental illness (Balf et al., 2008; Wheeler, Harrison, & Homes, 2009).

Recommendations to Improve Access to Primary Physical Care

Unequal access was recently underscored in the Centre for Addiction and Mental Health's (2010) response to the Human Rights Mental Health Strategy for Ontario. They recommended developing strategies that could improve the health care of mental health patients in an effort to improve their physical health. This Primary Care Action Plan includes linking mental health patients to primary care services in the community. While this is a necessary step forward, this linkage may serve to increase the segmentation of care because many people with severe mental illnesses have difficulty attending community-based primary care services. Other attempts to improve access to primary care services for those with mental health concerns have been limited in reach and are worth re-exploring (Crews, Batal, Elasy, Casper, & Mehler, 1998; Doey et al., 2008; Koyanagi, 2004; Marion et al., 2004). As one of the principles of the CCMHI Charter (2006) states: "All Canadian residents have the right to health services that promote a healthy mind, body, and spirit" (p. 2). It is therefore a necessity that those with mental health issues have suitable and adequate access to primary physical medical care within a continuum of care and co-location of services.

REVERSED SHARED CARE: AN INNOVATIVE APPROACH AT NYGH

It was noted in the Mental Health Department of North York General Hospital (NYGH) that many of the mental health patients in attendance did not have access to a primary care physician, despite having significant

medical concerns. In one instance a psychiatrist was prescribing a patient's insulin because of this patient's lack of access to a primary care physician. This is notable because NYGH is a community teaching hospital in an urban area with a large and active community-based family medicine department of over 365 affiliated family physicians/general practitioners and a community family health team. In 2009, NYGH developed a new service, recognizing the necessity of providing primary medical care to vulnerable populations, such as those with mental health concerns. Noting the benefits of collaborative and shared care, the importance of service integration, and building on previous innovative work in this field (e.g., Doey et al., 2008), they proposed to implement a form of collaborative care the authors of this paper have conceptualized as *reversed shared care*. Shared mental health care had been traditionally associated with a psychiatrist spending time and providing service in a family practice setting. It was felt that the descriptor "reversed" shared mental health care might capture the less-often-thought-of need for primary physical health care practitioners to spend time and provide service in psychiatric and mental health care settings.

Reversed shared care provides assessment and treatment for all patients of the NYGH Mental Health Department who do not have a primary care physician. A few exceptions were made due to patient preference for gender matching and for those who, due to symptoms of mental illness such as severe anxiety and/or hallucinations, were not comfortable in a typical primary physical care setting. All patients who attended the reversed shared care service were not currently under the care of a primary care physician.

The NYGH innovation in service delivery provides co-location of both primary medical care and psychiatric care in one clinic. Currently, the service is staffed by a family physician funded by public insurance (OHIP) and an Assertive Community Treatment (ACT) nurse. To assess the utility of NYGH's reversed shared care plan, a Reversed Shared Care Primary Care Pilot Project was conducted over a three-month period from January to March 2010.

Reversed Shared Care Primary Care Pilot Project

The Reversed Shared Care Primary Care Pilot Project for NYGH's mental health patients was initially developed with this main goal: To provide accessible primary physical medical care for one of our communities' most underserved groups and improve the health of our patients. Patients were recruited to the service through flyers sent out from within NYGH's mental health program and through word of mouth. Care providers in the mental health program were made aware of the service. They were able to offer the service to mental health patients who did not have a primary care physician and who they thought would benefit or were in need of this service. Because patients self-presented and voluntarily accessed the reversed shared care program, consent was implied by their participation in the service.

Over the three months (January–March 2010) of the Reversed Shared Care Primary Care Pilot Project a total of 25 patients were seen by the primary care physician. The age, gender, and diagnoses of these patients are included in Table 1. An OHIP-funded primary care family physician and an ACT nurse were available for appointments one morning per week. A primary care office was provided for use by this program and was co-located within the NYGH's Mental Health Community Day Treatment, Outpatient, and Outreach Services. There were a total of 50 office visits, including 25 first visits and 25 repeat visits (6 no-shows). The medical services and referrals received by these patients are outlined in Figures 1 and 2.

Table 1

Demographics and Diagnosis of New Patients Seen in Reversed Shared Care Program

	January–March 2010	April–October 2010
N	25	26
Gender	13 males 12 females	11 males 15 females
Age	Average age = 41.56 (SD=14.57)	Average age = 36.08 (SD=13.24)
Diagnosis Used by Primary Care Physician Note: More than one diagnosis possible per patient	Attention Deficit Disorder Angular Cheilitis Anxiety Asthma (2) Bipolar Affective Disorder Chronic Pain Colitis Crohn's Disease Diabetes Duodenitis Eczema Epilepsy Fatty liver Gastritis Gastroesophageal Reflux Disease (2) Gluten intolerance Headaches Hemorrhoids Hip Pain Hydrocele Hyperlipidemia Hypertension (2) Inguinal Hernia Insomnia Major Depressive Disorder (2) Neuralgia Obesity (3) Obsessive Compulsive Disorder Patellar Femoral Syndrome Pelvic Pain Peptic ulcer Rhinophyma Schizophrenia Sleep Apnea Substance Abuse/Dependence (4) Tremor Vertigo	Acid Reflux Anxiety (3) Asperger Syndrome Bipolar Disorder (4) Birth Control Bronchitis Cardiomyopathy Cholecystitis Chronic pain Colonic Polyps Constipation Depression (4) Diabetes Drug Induced Hepatitis Dysphonia Dysmenorrhea Dysuria Ear, Nose and Throat Facial Cranial Neuralgia Facial Neurotic Dermatitis Fetal Alcohol Syndrome Fibromyalgia (2) Frontotemporal Dementia Hematoma Hepatitis C Hypertension (4) Irritable Bowel Syndrome Impulse Control Disorder Metabolic Syndrome (2) Mixed Personality Nocturnal Palpitations Obesity (2) Polycystic Ovary Syndrome Post-concussion Headache Schizophrenia Septal Perforation Spastic Paraparesis Stress Substance Abuse/Dependence (5) Thalassemia Trigeminal Nerve Damage Xerosis

Figure 1

Primary Care Services Provided in NYGH's Reversed Shared Care Program

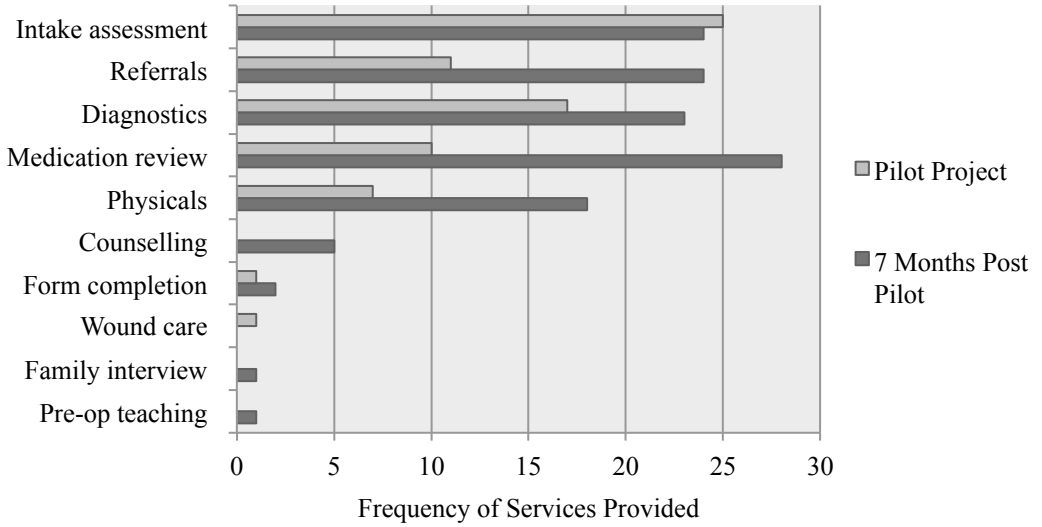
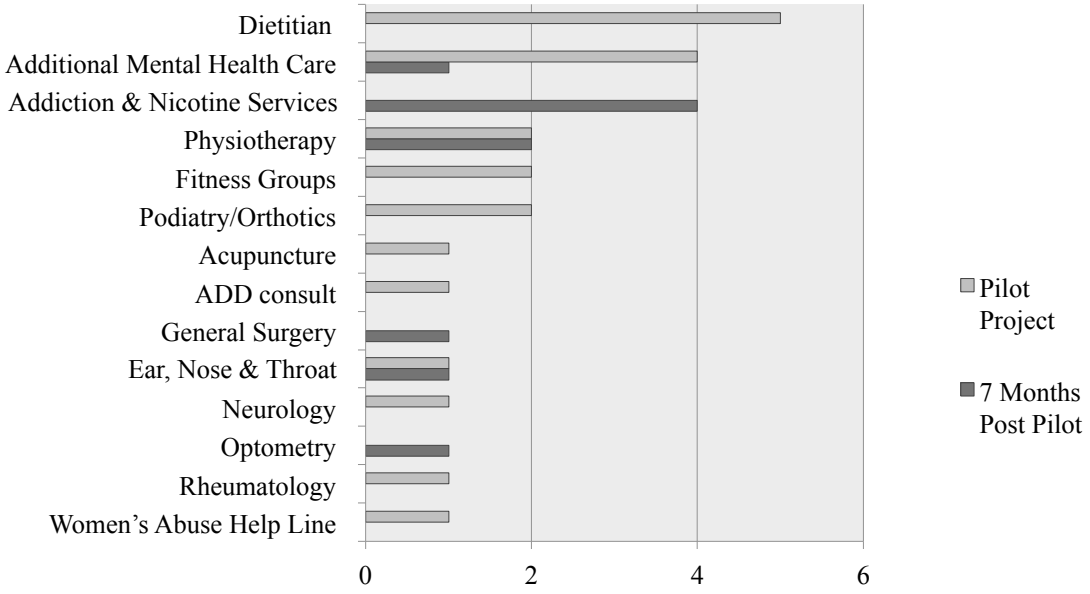


Figure 2

Referrals Made by NYGH's Reversed Shared Care Program



Continuation of Reversed Shared Care Primary Care Project

Because patients used the reversed shared care pilot project (i.e., they were assessed, treated, and referred), this service was extended, and in the subsequent seven months (April–October 2010), the primary care physician saw an additional 26 new primary care patients. The age, gender, and diagnoses of these patients are included in Table 1. During these seven months the frequency of visits increased, with a total of 110 visits, including 24 first visits and 84 repeat visits (4 no-shows). The medical services and referrals received by the patients during these seven months are also outlined in Figures 1 and 2.

DISCUSSION

These descriptive findings point to the utility of reversed shared care in that patients used the service, often repeatedly, and received physical health care and referrals to the appropriate services. Part of the first objective of this pilot project was thus achieved, as NYGH's mental health patients were provided with accessible high quality primary physical care. It has yet to be determined if the health outcomes of these patients improved directly as a result of this service; however, it has been shown that increasing access to primary care services does improve health outcomes (Starfield, Shi, & Macinko, 2005). Although not explored in the current report, Doey and colleagues (2008) found that creating a community health clinic within mental health care services decreased the number of hospital visits and admissions and decreased length of stay in hospital. Similarly, McGuire, Gelberg, Blue-Howells, and Rosenheck (2009) found that co-location of primary care services within a centre for homeless veterans with serious mental illness and substance abuse decreased emergency department use. It is thus expected that future monitoring of this Reversed Shared Care Primary Care service will also demonstrate decreased visits to the emergency department and improved patient flow.

Despite the obvious benefits of reversed shared care in improving access to medical services for those with mental health issues, there are many challenges in implementing this type of pilot project. Challenges include developing adequate financial, time, and resource remuneration. With respect to hospital budgeting, in a time of austerity, the reversed shared care team had initial challenges in securing administrative and institutional support. Budgets are often silos for a particular department or service, such as the mental health department versus the primary care department. One hospital program hosting another service, with perceived administrative costs, can be seen as a luxury, outside of the program's accountability. Despite their goals of patient-centred care, new models of organizing integrated clinical services challenge institution and administrative structures.

A main challenge of this program was the perceived increased financial cost in starting a "new clinic," particularly in a climate where hospital-linked community and outpatient services are being divested or discontinued, with the belief that patients will access these services in the community. The institution also viewed this co-location of multidisciplinary services as unnecessary and redundant given that there is an established primary care department. This is ironic because the main reason for the development of the reversed shared care program was to address a gap in care for a group of patients who face barriers in accessing existing community-based primary health care services.

The financial concerns of the administration resulted in the need for a system-wide and integrated vision of service delivery and resource allocation from decision makers, which was fortunately obtained for the

current program. In fact, approval for the pilot had to be "sold" to senior management with reassurances of no additional costs and using existing resources. In the current case costs were kept to a minimum with the physician being funded by public insurance, the re-tasking of an existing ACT team nurse, and the use of existing physical clinic space for the half day per week service. Equipment to develop the family physician primary care office located in the mental health day-treatment clinic had to be gathered from unused equipment in hospital storage or through staff donations. Additional buy-in for this program was developed by highlighting expected reductions in emergency room visits and reductions in hospital admissions for these patients by addressing their unmet primary care needs.

Despite having recognized the needs for these services for many years it was not until a proactive and committed family physician offered to participate that the necessary elements for such a service could be brought together. A willing and interested primary care family physician is considered an essential ingredient and stimulus to allow a reversed shared care project and service to exist. The commitment, passion, and dedication of many clinical and clerical staff, managers, and directors were also crucial to the successful development and implementation of the pilot project.

These challenges combined to make it difficult to "sell" this service from an administrative standpoint, as it was "new" and associated with cost in a time of financial restraint. In order to implement the Reversed Shared Care Pilot Project as a permanent service at NYGH and elsewhere, it will be be important to further address these concerns and barriers. To get approval for the pilot and continuation of the current reversed shared care program it took time, explanation, and good communication. Demonstrating the clinical activity, sufficient volume, and continued monitoring of future outcomes are required to maintain support for the service and build on the lessons learned. In fragmented delivery systems, through mental health and family medicine departments, patients' clinical needs may be outside the assumed scope of either department. Developing a service to meet gaps in care and unperceived patient needs challenged this segmented structure and required service organizers to think beyond the existing segmented scope, and focus on patient-centred needs.

The benefits of reversed shared care to this group of underserviced patients are expected to be considerable, as they will have suitable access to primary physical medical care. For health equity to be achieved for people with mental illness, health care services must be provided in manners that incorporate the specific needs of the patients, as seen in the current reversed shared care program. Moreover, improved service access and health equity are key areas of focus for health and policy planners, with the common goal of patient-centred care (Marmot & Bell, 2010; Sen, 2002). The hope is that this improved access to suitable and adequate medical care will assist these patients in living longer, healthier lives.

Additionally, best practices in interprofessional care suggest co-location of services as an indicator and facilitator of increased collaboration (Appleby, Dunt, Southern, & Young, 1999; Koyanagi, 2004; Craven & Bland, 2002). These best practices in interprofessional education (Curran, Ungar, & Pauzé, 2006) and interprofessional care (EnHANCE Ontario Project, 2010) describe competencies for collaboration that require understanding the role and scope of the practice of other disciplines, with learning opportunities through clinical team interaction. The current reversed shared care service provided the opportunity for hallway interaction and the development of relationships between the primary care physician and the mental health providers through an "embedded" family physician. These interprofessional interactions have been significant and in keeping with NYGH's previous experiences in establishing collaborative consultation

relationships between providers (Ungar & Jarmain, 1999). More specifically, it was observed that having a family physician on site and accessible for informal hallway interactions with mental health staff allowed for a furthering of the relationships among clinical team members in hopes of improved service delivery and, ultimately, improved patient outcomes. Through co-location the clinical team progressed from a multi-disciplinary mental health staff to an interdisciplinary team with mental health and primary care clinicians available to each other and to the patient. The collaborative consultation relationships between primary care and mental health providers were furthered by availability and structured informal social interaction. This co-location of service providers combatted service fragmentation and segmentation and created a more cohesive team and service.

Limitations and Future Directions

It is worth noting that the authors recognize the limitations of the directionality implied in the terms *shared* and r*eversed shared* care. Traditionally, shared care has referred to a psychiatrist bringing service to a primary care clinic. The new term *reversed shared care* is being used to draw attention to bringing needed primary physical health care services to a mental health clinic. Ultimately, however, the directionality of service should be to the patient or person with mental illness in keeping with patient-centred care. The term *reversed shared care* is thought to be of practical conceptual value for communicating and designing service delivery. Many agencies and hospital departments remain organizationally structured as separate departments (e.g., department of family medicine, department of psychiatry). The term *reversed* is useful for planners and organizers to develop and negotiate service provision with each other in language and concepts that resonate with their current inter-departmental models and structures. In true patient-centred care models, the directionality of consulting services between agencies and departments will be secondary or redundant, with the primary direction of service provision directly to the patient or person with mental illness.

There are a number of other limitations of the present descriptive study of NYGH's reversed shared care program that are worth mentioning. First, although this program was not developed specifically for particular populations of people with mental illness who experience inequalities in health, each patient was provided with individualized care. Future reversed shared care program development and research might look at creating programs that target gaps in care for populations of patients who are less likely to receive health services. For example, certain racialized communities are less likely to access health services as a result of inequities in living situations, low socioeconomic status, and lack of health insurance (Hargraves & Hadley, 2003; Kinnon, 1999; Williams & Jackson, 2005). Reversed shared care programs could be created specifically for these groups to improve access.

In addition, as the present study did not identify differences in the primary services provided and referrals made based upon the patients' diagnoses, age and gender, future studies should explore the demographic differences of the patients. A greater understanding of these differences might suggest how to further develop other reversed shared care programs for best effect.

Future studies could also build upon the results of the present study and provide future monitoring and evaluation of the utility and effectiveness of reversed shared care. This monitoring could include determining if reversed shared care programs demonstrate improved hospital patient flow by diverting patients from

presenting in the emergency department, thereby reducing wait times. It would also be interesting to determine if increasing access to primary care services for people with mental illness through reversed shared care programs does in fact improve health outcomes. Future evaluations should also ensure that patients are asked about their experience of the reversed shared care program, either through formal surveys or through qualitative individual interviews or focus groups.

Lastly, implications from this paper suggest the need to inform people living with mental health diagnoses, as well as service providers, of the comorbidity between mental and physical health concerns and the importance of increasing access to physical health care. This could occur through community educational events for the public, increased education for primary care physicians, improved communication between primary care physicians and mental health professionals, and enhanced communication and relationships between patients and their care providers. This paper also suggests that health care planners and policy makers reflect on the organization of service delivery in the hope of moving further toward true patient-centred care delivery as the primary concern and driver of service allocation and design.

CONCLUSION

The present study sought to discuss the significant comorbidity between mental and physical health conditions and the inequitable access to primary physical health care for people with mental illnesses. Based upon this disparity, the development of a reversed shared care program at NYGH was discussed and, preliminarily, descriptive data was provided. These very preliminary findings demonstrate the importance of future development, evaluation, and implementation of reversed shared care programs. It is hoped that providing people living with mental illness more suitable physical health care will ultimately serve to improve their physical and mental health.

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