Shared or segregated? Comparing perspectives on primary mental health care in Northern Ontario

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The Ontario psychiatric outreach programs

Les programmes d'extension en psychiatrie de l'Ontario

CRaMHR
Centre for Rural and Northern Health Research

What is "Shared Care?"

- Patient care shared by primary care provider and psychiatrist
- Interface between psychiatry/mental health and primary health care
- Differs from traditional referral relationship or "parallel practice":
  - Co-provision of care
  - Joint consultations, provider consultations
  - Higher levels of interdisciplinary communication & interaction

Goals of Shared Care Model

- To improve mental health care provided by FPs/GPs
- To reduce unnecessary or inappropriate referrals
- To improve access to psychiatry at community level
- To integrate primary & secondary care
- To improve quality & continuity of care

OPOP Research Project

Collaboration between CRaNHR and OPOP to examine models of psychiatric outreach in small Northern Ontario communities

Year One (2008-09)

- Literature Review – models of psychiatric outreach
- **Survey of OPOP-affiliated Consultants**
- **Focus Group Interviews with Consultants**
- **Survey of Family Health Teams**

Year Two (2009-10) with CPRN

- Community Case Studies

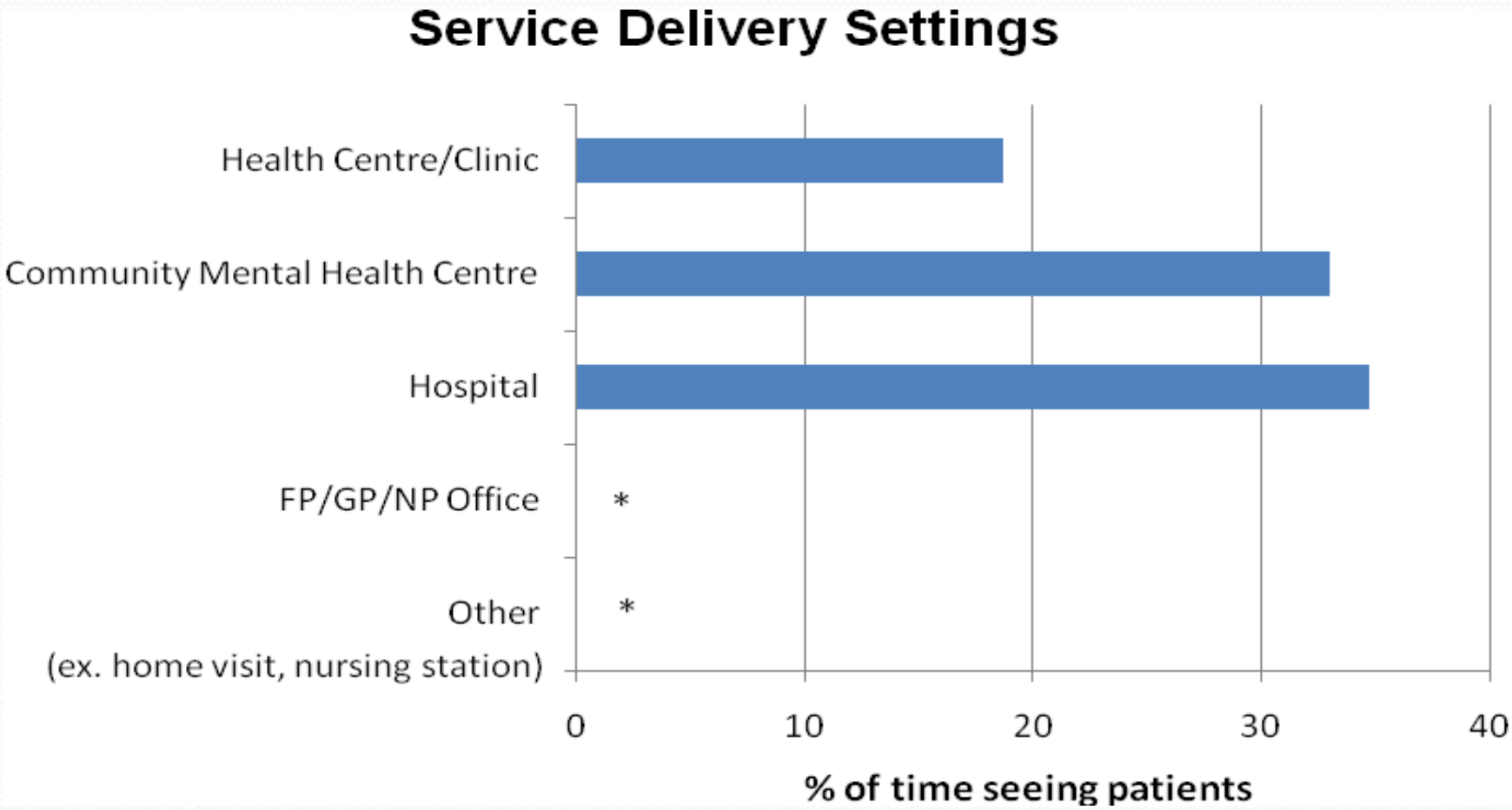
Thematic Focus

- What do OPOP consultants say about working with primary care providers?
- What do Family Health Teams say about working with psychiatrists (not specifically OPOP)?
- Based on these two groups, what can we say about "shared care" in small Northern Ontario communities?

1. OPOP Consultant Survey

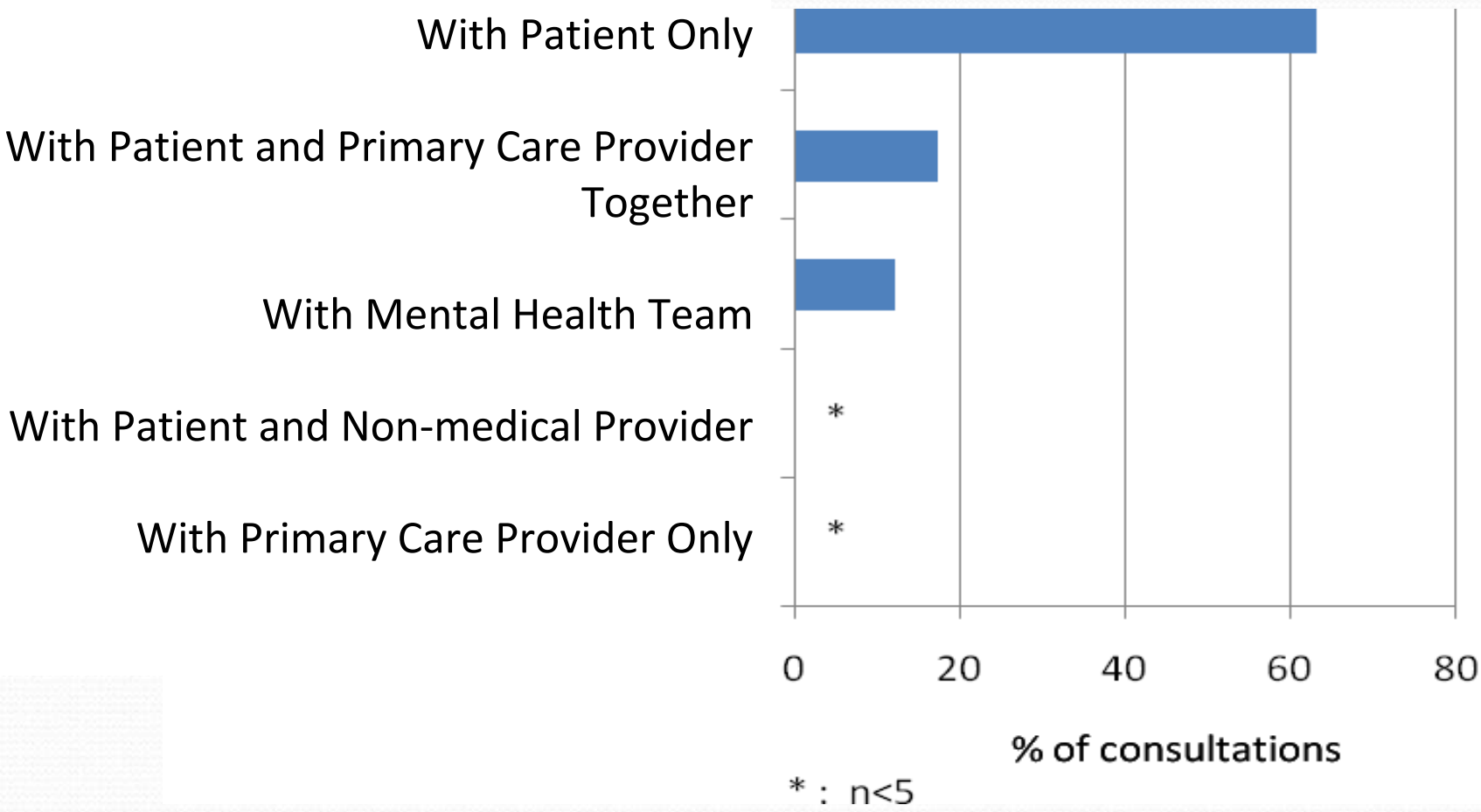
- Target Sample: All OPOP-affiliated consultants who perform outreach in the North
- Responses
  - 24 completed questionnaires from 22 OPOP consultants
  - A small number (<5) of non-OPOP consultants (responses excluded from this analysis)

Where do OPOP Consultants Work?



*: n<5

With Whom Do OPOP Consultants Work?



Survey of Consultants: Summary

- Most working in a secondary care setting
- Limited care provided in primary care setting
- Limited collaboration with primary care providers
- Parallel practice – most common model in relation to primary care
- A lot of variations among consultants, and many exceptions…

2. Survey of Family Health Teams

- An interdisciplinary team approach to delivery of primary health care
- A recent innovation in Ontario and little is known about how they operate
- Little information about how FHTs deliver mental health care

Survey of Family Health Teams

- Target sample: All operational FHTs in North East and North West LHINs, excluding North Bay, Sault Ste. Marie, Sudbury, Thunder Bay, Timmins (19 eligible as of July 2008)
- Semi-structured telephone interview with a "representative" of the FHT (selected by FHT).
- Completed 14 interviews between September-December 2008

Who Works in the 14 Family Health Teams

Physicians	**CURRENT (FTEs)**	**# FHTs**
FPs/GPs	61.5	13
Specialists	6	2
Non-Physician Staff		
Nurse Practitioners	20.5	13
Registered Nurses	17.5	11
Social Workers	6.5	7
Pharmacists	3.25	6
CMHW/Counselors	1	1
Health Systems Navigators	1	1
Others (e.g., Dieticians)	9.5	9

Availability of Non-Psychiatrist Mental Health Providers at FHTs

FHTs with mental health services (non-psychiatric)	# of FHTs	CUMULATIVE
At least one social worker	7	7
At least one CMHW/Counsellor	1	8
Visiting clinics (general mental health; methadone treatment; dementia)	4	9
Visiting MH Specialist	1	10

Integration of Psychiatry with FHTs

ON-SITE SERVICES	# of FHTs	CUMULATIVE
Visiting Psychiatrist at FHT	2	2
Telepsychiatry at FHT	5	6
Telephone support to FHT from psychiatrists nearest referral centre	3	6
OFF-SITE SERVICES		
Visiting psychiatrist in community (off-site) – accessible	6	10
NO INTEGRATION OF PSYCHIATRIC SERVICES		
Accessible but not utilized - Psychiatrists (at community hospital)	1	1
Not accessible - Visiting psychiatrist in community	5	3
No psychiatrist available	1	4

Perceived Access to Psychiatrist

"Regular and ready access to a psychiatrist?"

- Perceived/Utilized Access: 4

Perceived & Utilized Access:

- *"Yes. Well, with our two visiting specialists, they are very eager to be helpful, often we can get a call back within an hour. So they will do telephone consults. And, to the best of his ability, the one who does videoconferencing will try to see a patient soon if it's urgent."*

Perceived Access to Psychiatrist

"Regular and ready access to a psychiatrist?"

- Perceived/Utilized Access: 4
- Potential/ Unutilized Access: 2

Potential/Unutilized Access:

- *"Nope! The only thing that we would have access to is that if clients are already seeing a psychiatrist or saw a psychiatrist. I know some of the visiting psychiatrists would say, 'If you have any problem, you can reach me in Toronto, you know.' But it's not, it's just on an individual basis, it's not a formalized system. . . Well I have, on occasion, contacted the psychiatrist…It's not something that I do every day. But on the cases that I have, they were very good."* (Social Worker)

Perceived Access to Psychiatrist

"Regular and ready access to a psychiatrist?"

- Perceived/Utilized Access: 4
- Potential/ Unutilized Access: 2
- No Perceived Access: 8

No Perceived Access

- *"… we're feeling a really significant absence in support [from a] psychiatric consultant, and are using telehealth medicine referrals to try to fill that space, when that's the most appropriate thing. But, in the time that I've been here, I've seen the time frame for the referral … get really bogged down and long. Longer than what would be in the best interest of timely patient care."*

  (Social Worker)

From Access to Shared Care:

- *"Certainly, Dr. X who's in _____, and who also does our telehealth with North Network. The doctors are able to contact her. And I can always contact her too. . . She's always available. She always calls back. . . She has been [here] once to visit and take part in and do an education day with people, that was really great. I sit in on most of the interviews that we do with the patients, and she's really great about that.* ***Yeah, it's a real shared care model.*** *It works very well. " (Social Worker)*

Shared Care, 2:

- *"They would be managed by the family physician. But the family physician would be consulting with the visiting psychiatrist... Sometimes the visiting psychiatrist will manage the patients depending on how serious the problem is. The visiting psychiatrist will do the intake, interview and then recommend a plan of action, and then the family physician takes over. And when the visiting psychiatrist comes the following month, he would see the patient then."* (Nurse Practitioner)

Survey of Consultants: Highlights

- Little direct collaboration in primary care settings
- Collaborative interdisciplinary care occurred, but mainly at secondary level
- Some consultants identified lack of primary care providers in their outreach communities as a serious problem
- Some consultants thought primary care providers were not interested in collaborating

Survey of FHTs: Highlights

- FHTs recognize high levels of need
- Most had access to some community-based mental health services – many FHTs did not want to "duplicate services"
- Still identified MANY service gaps and barriers to mental health care
- Few had established effective relationships with a psychiatrist, even if a psychiatrist was working in the same community
- Many FHTs were focused on improving linkages and referrals to external providers
- FHTs were "under construction" and still evolving

Co-chair of a Northern Administrator's Group:

- *"It's my impression that most family health teams have not embraced or capitalized yet on the whole mental health piece. Most of them it seems, are focusing more on the medical side. . . Everybody's at different stages…some of them haven't even hired mental health workers yet! . . . And they look at me and go 'oh my gosh! How can you mess around in mental health stuff!' "*

In Conclusion

- The two surveys demonstrate a common picture:
  - Shared care, as a model of mental health service delivery, had not been widely adopted in smaller communities in northern Ontario
  - Primary health care and mental health care remained largely segregated – but it is improving!
  - Most FHTs lacked reliable access to a psychiatrist
  - But there are some examples of fruitful collaboration

Questions

- Why do so few OPOP consultants work in a primary care setting?
- For psychiatrists, what are the pros and cons of consulting at the primary care setting vs. the secondary level (e.g. hospitals, community mental health clinics)?
- What are the opportunities for increasing collaboration between OPOP and FHTs?