Mental Health Services in Smaller Northern Ontario Communities:

A Survey of Family Health Teams

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Mental Health Services in Smaller Northern Ontario Communities: A Survey of Family Health Teams

Main Messages

A survey of family health teams (FHTs) in smaller northern Ontario communities was conducted in the Fall of 2008, to examine the integration of mental health and psychiatric services within the FHT model. Representatives of 14 FHTs participated in semi-structured interviews. Key findings were:

- Some participants did not consider physicians to be part of their FHT because of the physicians' separate corporate structure and payment mechanisms. For others, this distinction was not relevant. Future research should be aware that some FHTs make this distinction, and explore the implications for collaboration.
- Northern FHTs reported disadvantages related to enrolment-based funding for interdisciplinary providers. Shortages of family physicians, as well as client populations unwilling to be enrolled, limited the number of enrolled patients. Recruitment difficulties were exacerbated for positions approved on a part-time basis. Northern FHTs desired a funding model that considered the realities of the northern context.
- Eight FHTs had hired at least one dedicated mental health provider (e.g. social worker). Some saw it as an add-on rather than a core service. To increase the integration of mental health care, mental health should be identified as a core service and labelled a priority.
- FHTs struggled to find a niche within the constellation of community mental health services. Three niches had evolved: "everything else" not covered by other organizations; "alternative choice" to other service providers; and "FHT specialist," focusing on the psychosocial aspects of health promotion and disease prevention. A tension exists for rural FHTs between the desire to "avoid duplication of services" and the FHT focus on patient-centered care; this issue warrants further research.
- Long distances to referral centres, lack of transportation services, and a strong ethic of keeping patients in the community translate into a need for effective community-based access to psychiatry. Six FHTs offered on-site services through a combination of visiting psychiatrists, telepsychiatry, and/or telephone support from a psychiatrist for indirect care. Six FHTs were also able to refer to a resident or visiting psychiatrist within the community, and three reported telephone access to a psychiatrist at the nearest referral centre. However, only four of 14 reported "regular and ready access" to a psychiatrist; telephone access was a key element.
- Five FHTs also reported visiting psychiatrists whose services were not easily accessible. Perceived barriers were long waiting lists, program eligibility restrictions or provider-based criteria (e.g. psychiatric sub-specialities), and the inability to directly contact the psychiatrist**.**
- Some FHTs reported the lack of consistency or continuity of psychiatric care as a challenge, when a patient sees a different psychiatrist with each visit. Visiting psychiatrists may improve their effectiveness if they coordinate care with referral centre psychiatrists.
- FHTs are a largely untapped audience for mental health education and training, with special needs related to primary mental health care and the psychosocial aspects of chronic disease management. As FHTs also fill critical gaps in "traditional" mental health services, these topics remain important.
- Participants reported that most family physicians preferred to refer to specialists rather than collaborate in mental health care. Other providers, particularly those providing mental health services, expressed interest in improved access to psychiatry. FHTs represent an opportunity for the Ontario Psychiatric Outreach Program (OPOP) to increase outreach services to the primary care level.

Mental Health Services in Smaller Northern Ontario Communities: A Survey of Family Health Teams

Executive Summary

The Ontario Psychiatric Outreach Program (OPOP) and the Centre for Rural and Northern Health Research (CRaNHR) at Laurentian University collaborated on a multi-method, multi-phase research project. This report addresses the findings of one piece, the Family Health Team Survey. The purpose of this study was to understand how mental health services were being integrated within Family Health Teams (FHTs). This study focused exclusively on FHTs in smaller communities located outside the northern urban referral centres (NURCs), in the North East and North West Local Health Integration Network (LHIN) regions.

Fourteen of 19 eligible FHTs participated in telephone interviews in the Fall of 2008. FHTs were provided in advance with the question guide, and asked to select a representative to participate in the interview. The semi-structured interviews elicited information on FHT membership and practice characteristics, integration of mental health and psychiatric services, and education and training needs related to mental health services. Interview transcripts were analyzed using a descriptive content analysis approach. A small number of unprompted themes were identified.

FHT Membership and Practice Characteristics

FHTs in this sample varied greatly in terms of size, team composition, and spatial organization, as well as length of time since beginning operation as a family health team. For example, the number of family physicians/ general practitioners (FP/GPs) per FHT ranged from 0-14, with a mean of 4.75 FTEs. Pre-FHT history and relationships appeared to have a greater influence on the FHT than the length of time since incorporation. Many emphasized that they were still in the early stages of development; others emphasized the uniqueness or individuality of FHTs, and the hazard of generalizing from one FHT to another.

Despite the Ministry of Health and Long-Term Care's description of Family Health Teams as inclusive of physicians, not all FHTs considered the physician group to be part of the FHT. This was related to the fact that physicians were not "employees" or paid by the FHT, but incorporated as a separate physician group. Respondents often had to be prompted to include the physicians' perspective in their responses, and some stated they could not. However, this distinction was not relevant to all participants. Future research on FHTs should be aware that some FHTs make this distinction, and explore the implications for team-based and collaborative practice.

Limitations on northern FHT development. Because funding for interdisciplinary providers is linked to the number of enrolled (or rostered) patients, FHTs in the north faced disadvantages to growth and development. Shortages of family physicians were seen as the primary limiting factor on FHT development, as enrolment was dependent on the number of physicians. Four FHTs had a combined seven vacancies at the time of the interview. A related frustration was that nurse practitioners were not allowed to roster patients. The second challenge was community attitudes toward enrolment; resistance to rostering was a particular challenge in communities with large First Nations populations. As a result, some FHTs struggled to meet the needs of their communities. Unrostered patients frequently had no choice but to continue seeking care at hospital emergency departments. Finally, many positions had been approved on a part-time basis only; the majority of vacancies on FHTs were for part-time positions, which were even more difficult to fill than full-time positions. These issues suggest the need to consider alternatives for funding interdisciplinary providers in the north.

Integration of Mental Health Services

At the time of the survey, slightly more than half of the participating FHTs had a dedicated mental health professional on staff, and 10 of the 14 had integrated some degree of mental health service within the FHT. With a few exceptions, family physicians and nurse practitioners were seen as playing a primarily supportive role with regard to mental health services, usually

preferring to refer to specialists. Eight of the FHTs had added at least one mental health professional (social worker, community mental health worker) to the interdisciplinary team, who provided counselling, assessment, and referral and system navigation services.

However, nearly half of the FHTs had not yet hired any mental health staff; this did not appear to be related to the length of time since beginning FHT operation. There was no apparent association between integration of mental health services with the age or size of the FHT. According to some informants, this depended more on level of comfort with mental health care of the FHT managers / administrators, as well as the family physicians. It was also seen as a consequence of FHTs' (medical) focus on chronic disease priorities. Some also saw mental health as an "add on" rather than a core service. To increase the integration of mental health care, mental health should be identified as a core service and labelled a priority.

Niche within mental health services. Mental health providers within FHTs struggled to find a niche within the constellation of community mental health services. A majority were concerned that they "not duplicate services" of other mental health organizations, and tried to provide "everything else" not covered by others' mandates. Although this concern was about maximizing limited resources, it was also about respecting other professionals' "turf" and mandates. In contrast, a minority rejected "duplication" as a problem, endorsing the view that they were increasing accessibility, patient choice, and providing a one-stop integrated service, consistent with the FHT mission of patient-centered care. A third group was attempting to further specialize in mental health services specific to the primary care mission of the FHT, such as the psychosocial aspects of health promotion, disease prevention, and chronic disease management. The apparent tension between a desire to maximizing scarce resources and the FHT mandate to provide patient-centered services may be a unique challenge for FHTs in rural and remote Ontario, and may warrant further investigation.

Integration with Services of Psychiatrists

A strong ethic of keeping patients in the community was also expressed, reinforcing the need for local access to psychiatrists, in addition to those provided by other mental health professionals. Ten FHTs reported awareness of a psychiatric outreach consultant or visiting psychiatrist in the community and two reported on-site services. References to psychiatrists are not necessarily OPOP-affiliated psychiatrists. Although half of the FHTs were located in communities that received OPOP-affiliated outreach services, none were familiar with the "Ontario Psychiatric Outreach Program" name prior to the survey. OPOP programs may benefit from increasing communication and visibility within such communities.

Ten FHTs reported the integration of at least one mode of psychiatric service delivery which enabled them to provide some care within the community. Six FHTs offered on-site services through a combination of visiting psychiatrists, telepsychiatry, and/or telephone support from a psychiatrist for indirect care. Six FHTs were also able to refer to a visiting psychiatrist within the community. Only two reported visiting psychiatrists providing services onsite; another two reported telephone support from psychiatrists at the nearest referral centre. Two FHTs described their model of psychiatric service delivery as "shared care" (one with a referral centre psychiatrist via telepsychiatry, one with on-site services from a visiting psychiatrist).

Despite the availability of various modes of psychiatric service delivery, only four FHTs reported having regular and ready access to a psychiatrist. Five FHTs reported having a visiting psychiatrist within the community whose services were not easily accessible to the FHT staff or patients. Perceived barriers to psychiatric services in the community were long waiting lists, program eligibility restrictions or provider-based criteria (e.g. psychiatric subspecialities), and the inability to directly contact a psychiatrist when needed. Availability of telephone support from a psychiatrist was key to the perception of good access.

Continuity of care. A minority of FHTs voiced frustration over frequent changes to care plans that result when a patient saw a different psychiatrist at each visit or service site. While in some cases there could be multiple visiting psychiatrists, or turnover in visiting psychiatrists, the main concern was over inconsistencies in recommended or prescribed treatments between visiting psychiatrists and referral centre psychiatrists. FHTs expressed a strong desire for having a consistent

relationship with one or two psychiatrists. OPOP and other visiting psychiatrists may see improved effectiveness of their service if they establish relationships with psychiatrists at the northern urban referral centres. Although this was not a global concern in this sample, the fact that the issue was unprompted and raised by multiple FHTs suggests the need for further investigation.

Education and Training Needs

A majority of FHTs preferred education/training modalities that allowed them to remain in the community. Although most agreed that on-site training would be the most useful, it was viewed as "unrealistic." Participants were accustomed to distance-based modalities (internet, videoconference) and found them acceptable. Some preferred having training accessible to the entire FHT or other professionals within the community, to enhance team practice and community collaboration. For others, lack of a "critical mass" was a barrier to attracting in-community opportunities. Several participants expressed doubt about other team or community members being interested in the same training, and many reported that mental health training was not a high priority among other FHT staff.

The topics of interest most frequently cited were anxiety, depression and other mood disorders, and senior's mental health, followed by personality disorders, and the mental health aspects of chronic disease management. These were related to perceived gaps in services in the community, often the types of conditions not covered by other organizations with mandates restricted to services for persons with serious mental illness (SMI). Other topics were unique to the FHT mandate. FHTs represent a largely untapped audience for interdisciplinary mental health care education and training programs, with a focus on primary mental health care and the psychosocial aspects of chronic disease management. "Traditional" topics remain important, particularly for disorders or conditions not covered by services for persons with SMI.

Next Steps

This study is the third component of a larger study. Two other components focused on the practices of psychiatric outreach consultants; of particular interest is the ability to compare perspectives on each side of the primary care-secondary care interface, particularly on the topic of shared care. A planned comparative analysis will focus on patterns of interactions between psychiatrists and primary care providers in smaller northern communities. A final study component consists of community case studies that examine the integration of mental health services from the community perspective. Synthesis of all study components will provide multiple points of data to examine specific themes from multiple perspectives.

Mental Health Services in Smaller Northern Ontario Communities: Survey of Family Health Teams

1. CONTEXT

Family Health Teams (FHTs) represent one model of collaborative care, more specifically an interdisciplinary team-based approach to the delivery of primary health care. Because FHTs are a relatively new innovation in Ontario, few data exist on their composition or practice characteristics, and even less is known about current and planned efforts to integrate primary mental health care within FHTs, particularly in smaller communities with fewer resources. And, although FHTs are designed to promote collaborative care within the team framework, it is unknown how this collaborative practice extends to external providers of mental health care or how FHTs interface with specialist services.

The Ontario Psychiatric Outreach Program (OPOP) is funded by the Underserviced Areas Program of the Ontario Ministry of Health and Long-Term Care (MOHLTC) and supported by seven partner programs. OPOP-affiliated psychiatric outreach consultants provide clinical services through outreach, distance-based clinical and support services via telepsychiatry, and educational services to participating communities. OPOP also exposes undergraduate and postgraduate medical students to rural and remote practice settings.

Since OPOP was established in 1999, there have been several developments in mental health reform which have become important influences in the delivery of mental health services. With the recognition that most mental health services are delivered at the primary care level,[1,2,3,4] the recent development of FHTs has directly linked primary care with mental health professionals. This is consistent with the promotion of "shared care" or "collaborative care" approaches to the delivery of mental health services across Canada, in which there is collaboration between family physicians and mental health professionals.

The Family Health Team (FHT) Survey is one piece of a larger research project conducted by the Centre for Rural and Northern Health Research (CRaNHR) in collaboration with the Ontario Psychiatric Outreach Program to examine models of psychiatric outreach in smaller northern Ontario communities. This study describes the extent to which northern FHTs are integrating mental health services as an essential component of primary health care, both within its interdisciplinary team-based model and in its interactions with external providers of mental health care. FHTs in rural, remote and underserved communities in northern Ontario were surveyed to address the following research questions:

1. What are the FHT membership and practice characteristics in smaller northern Ontario communities?
2. How and to what extent have mental health services been integrated into FHTs?
3. How do FHTs integrate with psychiatry, including visiting psychiatrists?
4. What education and training needs do FHTs have related to mental health?

Answers to these questions will also address the larger project's broad research questions on models of psychiatric outreach service delivery.

1.1 Overview of Family Health Teams

As part of the Ontario government's "Family Care for All" strategy, FHTs are interdisciplinary care organizations designed to improve access to comprehensive primary health care services for residents of Ontario.[5] The FHT strategy has a number of goals, including increasing access to primary care providers for "orphan" or unattached patients; providing relief to emergency departments by improving access to non-emergency care; and, improving quality of primary health care though the provision of "comprehensive, accessible, and coordinated family health care services to a defined population."[6] FHTs were designed to:

- Support collaborative, interdisciplinary care from a range of health care providers by

supporting the co-location of family physicians, nurse practitioners, and other providers (nurses, dieticians, etc.)

- Provide extended evening and weekend coverage
- Focus on chronic disease management, disease prevention and health promotion
- Provide "system navigation" and care coordination by linking with other providers in the community and with other levels of care

The FHT model was designed to be flexible to support the varied needs of communities and providers, including flexible governance models and payment schemes. Governance frameworks included community-based FHTs, provider-based FHTs, and a mix of community- and provider-based FHTs,[7] depending on board membership. In rare cases, where a single community-based hospital was capable of providing organizational leadership, a community-based hospital FHT would be permitted. The number of providers and mix of disciplines is determined in part by community needs.[6] Patients are enrolled to participating physicians, and although patients are not required to be enrolled, funding for interdisciplinary staff is based on the enrolled population and demonstrated need.

The first wave of family health teams were established in 2005. At the time of this study, three implementation waves had taken place, resulting in 150 FHTs located throughout Ontario. In the north, 10 FHTs were established in the first wave, 6 in the second wave, and 12 in the third wave, for a total of 28 approved FHTs at the time of the study. This meant that some FHTs had been functioning longer than others, and that some had only recently been incorporated.

1.2 Models of Mental Health Service Integration

Since 2003, the Canadian Collaborative Mental Health Initiative (CCMHI) has been working to advance a vision of collaborative mental health care within primary care.[8] Its comprehensive Paper Series includes an annotated bibliography and targeted reviews, including one focused on rural and isolated Canada.[9,10] According to the CCMHI framework, the consumer-focused goals of collaborative mental health care are increased access, decreased burden of illness, and optimized care.[11] Models of collaborative mental health care may vary on four key elements: accessibility, collaborative structures, richness of collaboration, and consumer centeredness.

Despite this variability, the literature on collaborative mental health care is dominated by the "shared care" model. Although "shared care" can be used to refer to interdisciplinary care in general, for this study, shared care focuses on the interface between primary and secondary health care, where patient care is shared by a primary care provider and a psychiatrist or other mental health specialist. In most descriptions, shared care differs from a traditional referral relationship by the degree of interaction between the family physician and the specialist, in terms of higher levels of shared decision-making and joint management of patient care. Other elements of the model usually include joint consultations, indirect care, and a high degree of communication. Examples of shared care in Ontario include the Hamilton Program[12,13] and the Ottawa Share Program.[14] As these examples suggest, most research on collaborative mental health care and shared care has occurred in urban settings.[10]

Where some models of collaborative care focus on the clinical aspects of integration, other integration models focus on the organizational or institutional arrangements that facilitate collaboration. In the U.S., Bird and colleagues (1998) conducted a survey of rural primary care providers to explore rural models of integration.[15] Building on earlier work that identified integration models based on patterns of interaction, researchers identified four overlapping models of integration at the rural primary care organization level. The authors also reported on rurality factors influencing integration strategies, which included a shortage of mental health professionals; availability of office space with sufficient privacy for mental health services; distance from continuing medical education (CME) opportunities to maintain professional licensures; reimbursement for CME; and community attitudes.

Availability, accessibility, and utilization. Integration strategies can include the development of in-house services or integration with existing (external) service providers. In the case of specialist services, most FHTs can be expected to interface with some external services. For the purpose of this study, if a psychiatric service was available, accessible, and utilized,[16] then the FHT was considered to have integrated that service.

"Availability" refers to the simple presence or absence of a provider or service, or services that are geographically or "potentially accessible." "Accessibility" is a multidimensional concept that covers individual and organizational determinants of who can actually use a service, and "utilization" is the actual use of a service. "Perceived accessibility" differs from "objective accessibility" in that it is a subjective measure of knowledge and beliefs, and findings may differ from those of objective measures. Its value lies in capturing those aspects of accessibility that objective measures cannot, including awareness of, experience with, and barriers to service use, as well as satisfaction. Perceived accessibility is thought to be a more reliable predictor of utilization than objective measures.[17]

1.3 Prior Research on Family Health Teams

To date, few research studies have been published that focus on Ontario's Family Health Teams. Of those identified, most focused on the provision of mental health care in FHTs. A review and meta-analysis of telehealth by Hogenbirk et. al. (2006) concluded that FHTs could utilize information technology to augment mental health services, particularly in rural and remote areas.[18] Kates (2008) describes a shared care mental health initiative that began in 1994, and has continued with the reorganization of primary care into FHTs.[13] Based in Hamilton, the program coordinates the services of mental health counsellors and psychiatrists in 80 primary care practices in the city. According to Kates, results from the program evaluations influenced the establishment of FHTs.

Mulvale and Bourgeault (2007) describe the influence of global, local, and team factors on the provision of collaborative mental health care in FHTs, with the goal of developing a framework to understand barriers and facilitators of interdisciplinary mental health care.[19] While global factors (MOHLTC policies, funding, financing, remuneration) would affect all teams equally, they could have differential effects on FHTs when they interact with local factors (population health needs, provider supply, geography, technology) and within team factors (degree of hierarchy, professional cultures and practice styles, team vision, and communication).

In a second article, Mulvale and colleagues (2008) test this framework using case studies of eleven FHTs, three of which were rural.[20] The case studies focused on how contextual factors influenced the mix of providers and quality of collaborative mental health care. "Geography" was a factor for the three rural FHTs, but not the urban FHTs, where community quality-of-life issues resulted in difficulty in recruiting and retaining providers. This in turn limited the range of community mental health services with whom to collaborate, and the support available to primary care providers. The limited supply of local mental health services also resulted in rural FHTs emphasizing "working with existing services and not duplicating them."

Definitions. The term "interdisciplinary provider" has been adopted from the MOHLTC guides for Family Health Teams.[21] The category includes all non-physician health professionals. For this study, mental health providers refer to social workers, community mental health workers, and other non-psychiatric mental health specialists. Although psychiatrists are mental health professionals, "mental health" and psychiatry have been analyzed separately to highlight patterns specific to psychiatry for the benefit of OPOP. Finally, only half of the FHTs are located in communities with OPOP-affiliated services; in this study, psychiatrists, visiting psychiatrists, and/or psychiatric outreach consultants do not necessarily refer to OPOP-affiliated psychiatrists.

2. APPROACH

A telephone survey was designed to elicit information on (a) general FHT practice characteristics and (b) mental health services. A semi-structured approach was used to elicit data on specific questions, but also to allow for additional information in open-ended responses. The study protocol was reviewed and approved by the Research Ethics Boards at Laurentian University, University of Ottawa, University of Toronto, and the University of Western Ontario.

Study sample. Eligibility criteria for FHTs were (1) located in LHINs 13 and 14 but outside of the larger cities, (2) included on the MOHLTC public contact list of FHTs, and (3) were operational at the time of the

interview. As the focus of the study was on FHTs in a rural, remote, and underserved contexts, FHTs located in the northern urban referral centres (NURCs) of North Bay, Sault Ste. Marie, Sudbury, Timmins, and Thunder Bay, were excluded, as was Parry Sound for its relatively good access to services in southern Ontario. Because of privacy legislation, the only FHTs accessible to researchers were those who had provided written consent to the MOHLTC to make their contact information publicly accessible. Twenty-one FHTs met the first two criteria, however only 19 were found to be operational when contacted.

Recruitment and participation. FHTs were initially contacted by CRaNHR researchers by telephone to inform them about the study, and offered an information package that included a copy of the question guide. FHTs were requested to select a "representative" to participate in the interview. Once a representative nomination and consent form were returned by the FHT, a CRaNHR researcher contacted the representative to schedule a telephone interview. Of the 19 eligible FHTs, 14 agreed to participate and nominated representatives; all 14 representatives completed interviews. Halfway through the recruitment process, the Ministry of Health and Long-Term Care sent a letter to FHTs indicating support for the study; approximately half of the participants responded after receiving this support. Half of the FHT representatives who participated were social workers; the rest were administrators, nurse practitioners, and a family physician.

Data collection and analysis. A telephone interview guide contained 30 items designed to elicit information on FHT practice characteristics, existing and planned capacity to provide mental health services, relations with external mental health service providers including OPOP, access to specialist services including telepsychiatry, and barriers and facilitators to integrating mental health care within the Family Health Team service structure. Recruitment and data collection took place throughout the fall of 2008. Two researchers jointly conducted the interviews, each of which lasted about 45 minutes. The interviews were audiorecorded and transcribed verbatim, and reviewed by both team members.

The initial approach to data analysis was a descriptive content analysis. The transcripts were coded by question item and analyzed using NVivo v.8 software, a qualitative data analysis tool. Information not corresponding to a direct question was coded and analyzed using an inductive thematic approach. Most of this type of information was specific to individual FHTs; three new themes emerged with broader relevance and are reported here.

Study limitations. Participating FHTs were selected from smaller northern Ontario communities and do not represent FHTs more generally, but are specific to the geographical context. Second, although the participation rate of 74% is high, the sample size remains small. Results also indicate a high degree of variation among FHTs. Finally, as a practical limitation to this study, it was not possible to speak to all FHT members; the methodological approach of using a single representative to respond for the organization likely contributed to the variability. The physicians' perspective in particular is believed to be underrepresented. These limitations should be considered when interpreting the findings.

3. RESULTS

3.1 FHT Team and Practice Characteristics

3.1.1. Organizational history & governance

Representatives were asked about when the FHT had been approved, and how long they had been "functioning" as an FHT. Five reported approval in 2005, six in 2006, and the remainder reported 2007 or did not know. After approval, some FHTs reported being up and running relatively quickly, while others took longer to organize, apply for development grants, and hire staff. When asked about how long the group had been actually functioning as an FHT, half reported functioning for more than 2 years, and the other half for 2 years or less.

Pre-existing organizational relationships. The reorganization of primary healthcare services into family health teams represented a wide range of experiences in terms of organizational change. In some cases, the reorganization appeared to represent little more than a name change and some new staff. In other cases, it meant the consolidation of multiple provider groups, relocation of practices, loss of old staff and recruitment of new. And in some cases, the interdisciplinary team concept represented a catalyst for a new way of organizing patient care. For most FHTs, however, at least some pre-existing relationships and practices could be difficult to distinguish from current or evolving FHT practices. Some suggested that the study was "premature," or at least an unusual time to conduct the survey.

> *Just the history of it, in the sense that the family health team comprised of X family physicians who came from three separate clinics. They're now amalgamated into one clinic . . . And the reality is that we're still in the growing phase, so the idea of having a social worker in the same, and working with the physicians is still relatively new to these guys. So from a patient, from a community perspective it's a growing concept.*

Most emphasized that the FHT was still undergoing development and rapid change, and wanted to ensure that, in using the information, the researchers emphasized the newness of the FHT and the transitional nature of its operations.

Governance arrangements. Half of the FHTs reported a provider (physician)-based governance arrangement, with five reporting a mixed provider- and community-based arrangement. Only one reported a community-based arrangement, and one reported "other," having one of the unusual hospital-based arrangements. For one of the "mixed" FHT boards, all members were physicians, albeit the majority being "community based" (that is, not part of the physicians group providing services within the FHT).

Definition of "Family Health Team." One of the surprising difficulties encountered in the study was that the meaning of "family health team" varied from organization to organization. Despite the MOHLTC definitions focusing on interdisciplinary primary healthcare teams that includes family physicians, nurse practitioners, nurses, and other healthcare professionals, some family health teams did not consider the physician team to be part of the FHT. This resulted in some confusion between these participants and the interviewers, who understood the term "family health team" to be inclusive of family physicians. For example, one participant initially reported that there were no physicians on the FHT. The question was revisited when the participant later mentioned working with physicians. This led to the explanation that since the physicians were not employees of the FHT (e.g. not paid out of the FHT budget), they were not considered members of the FHT, even if co-located and working with the "actual" FHT staff.

> *Physicians that are employed by the Family Health Team? I have none . . . I know it sounds like we're two separate organizations, which we are,* ***legally****. We're two separate corporations... We both work in the same building . . . we work together as if we were one organization.*
>
> *So when we talk about our family health team, there are no physician members of our family health team . . . See, some Family Health Teams have physician employees, ok? We don't.*

This problem was not anticipated, but the interviewers adapted by asking the participants to include the physicians' perspective. For some respondents, however, it is unclear whether their responses represented the perspective of the interdisciplinary professionals only, or the entire group including physicians. And, a small number pointedly indicated that they did not know the physician perspective, and could not speak for them.

On the other hand, because they were provided with the interview guide in advance, some participants indicated that they had consulted with various members of the team (physicians and interprofessional providers alike) prior to the interview in order to better represent the team perspective.

This confusion unexpectedly highlighted an important feature of governance arrangements, the distinct

corporate structures for physicians versus the rest of the interdisciplinary staff, and the impact it may have on perceptions of team membership. However, the separate corporate bodies were also present for highly integrated teams who did not distinguish between the two, and no pattern could be identified to indicate why the distinction was more salient for some FHTs than others.

3.1.2. Physicians

The challenges described above complicated the seemingly simple task of counting the physician members of the Family Health Team. For the present purpose, the physicians include (a) physician employees, (b) members of the Family Health Network (FHN) or other physician corporation affiliated with the FHT, and (c) non-employee, non-FHN physicians who were co-located with the FHT and worked collaboratively with the FHT. The rationale for including all three groups was to represent the *de facto* extent of medical services that were available through family health teams, regardless of corporate structures.

Respondents were asked to provide the number of full-time or part-time physicians working with the FHT. They were also asked to distinguish between family physicians / general practitioners (FP/GPs) FP/GPs with additional certifications (e.g. anaesthesiology, OB/GYN), and specialists (e.g. surgeons, OB/GYN). Respondents often provided "approved positions" rather than current providers, and discussions frequently turned to vacancies and recruitment issues.

A total of 80 physicians were reported working with these 14 FHTs. Of these, 74 were FPs/GPs, of whom 18 were reported to have additional certifications in anaesthesiology, OB/GYN, emergency medicine; a small number had multiple certifications. Of the 74 FP/GPs, 15 were in part-time positions, resulting in 66.5 FTE FPs/GPs. There was a range of 0-14.5 FTE FPs/GPs per FHT, with a mean of 4.75 FTEs. Six FTE specialists were also reported.

At the time of the interview, all but one FHT had at least one family physician; one FHT had lost its only physician and was headed by a nurse practitioner. As well, one FHT consisted of only the physician group and administrative staff at the time of the survey (no interdisciplinary providers). Four FHTs had a combined seven vacancies for FP/GPs. Only two FHTs included specialists (a combined total of 6 specialists), and a third FHT had two vacant part-time specialist positions. At the time of the interview, no family health team included a psychiatrist; one had had a part-time psychiatrist position approved, but was skeptical about being able to fill the position on a half-time basis.

Table 1. Number of Physicians working with FHTs (Full-time Equivalent), and number of Physician Vacancies

	FILLED POSITIONS		VACANCIES	
	# FTEs	# FHTs (n=14)	# FTEs	# FHTs (n=14)
FP/GPs				
FP/GP	48.5	13	7	4
FP/GP+Additional Certification	18.0	6	-	-
FP/GP TOTAL	66.5	13	7	4
Specialists				
General Surgeon	4	2	-	-
OB/GYN	[†] 1	1	-	-
Paediatrician	1	1	-	-
Cardiologist	-	-	.5	1
Psychiatrist	-	-	.5	1
SPECIALIST TOTAL	6	2	1	1

Current: Physician positions filled at time of interview.
Vacancies: Approved positions, unfilled at time of interview
Additional certifications reported: anesthetist; surgeon+anesthetist; anesthetist+OB/GYN; OB/GYN; geriatrics. Some functions were reported such as coroner, emergency department, and delivery services, without certification; these were not included.
FTE: Full-time equivalent
FP/GP: Family physician/General Practictioner
[†] Near retirement.

3.1.3. Interdisciplinary providers

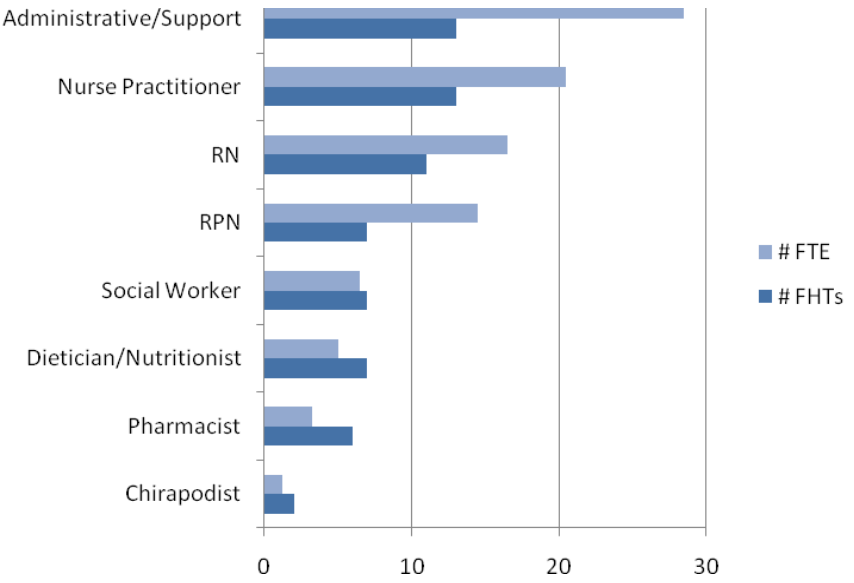
Administrators and support staff were the most numerous FHT staff, however this category constitutes a wide range of positions (e.g. clinic managers, administrators, receptionists, clerical staff). Among the care providers, nurse practitioners and nurses were the most numerous; all but one of the FHTs had at least one nurse practitioner on staff. Registered Nurses (RNs) and Registered Practical Nurses (RPNs) were the next most common disciplines. Half of the FHTs had

social workers. Dieticians/ nutritionists, pharmacists, and chiropodists were present at more than one FHT, albeit many on a part-time basis.

Other disciplines reported by a single FHT (1 FTE) were chronic disease manager, health systems navigator, and community mental health worker/counsellor. The following positions were reported by a single FHT at less than one FTE: Respiratory tech/therapist, epidemiologist, and physician assistant. (See Appendix B for a complete list of interprofessional staff and vacancies).

Eleven of the 14 FHTs had staff vacancies, with a cumulative 7 vacancies for full-time RNs (one additional for an RN/chronic disease manager), and 4 vacancies for full-time nurse practitioners. Other vacancies for full-time positions included a health educator and a case manager. The majority of vacancies were for part-time positions, for the following disciplines (more than one vacancy): chiropodist, social worker, dietician/ nutritionist, and pharmacist. Single part-time vacancies existed for a respiratory therapist and a community mental health worker. Only 6 positions had been requested but had not yet received approval from the MOHLTC. As with physicians, part-time vacancies were perceived as difficult to fill, particularly if the FHT had to recruit outside the community, as professionals might be reluctant to relocate for part-time employment.

Figure 1. Interdisciplinary providers by # of number of FTE positions, and by number of FHTs reporting provider type (among disciplines reported by more than one FHT)



3.1.4. Patient enrolment ('Rostering')

Twelve of the 14 FHTs reported seeing non-rostered patients. In some cases, the FHT was still in the process of rostering patients in their catchment area. In a couple of cases, a family physician had left the area and the FHT was rostering these newly-orphaned patients. However, a major reason for having non-rostered patients was a shortage of family physicians in the community. FHTs could only roster a certain number of patients based on the number of family physicians. In some cases, an insufficient number of family physicians resulted in a significant number of unrostered patients in the community. Some FHTs indicated frustration that nurse practitioners could not roster patients. In the case of the FHT that had lost its only family physician, none of the 2,000 patients could be rostered

until a new physician joined the team. Even where the FHT reported seeing unrostered patients, not all could be seen; one FHT reported that the majority of unrostered patients had to go to the emergency department to see a physician.

> *But we only have about half of [our population] rostered, because of our... Because we're short physicians, the physicians aren't taking on very many more rostered patients. . . So, that's really frustrating to me because my funding with the Ministry of Health is tied into how many rostered patients the doctors have.*

A third reason for having non-rostered patients was that the concept of rostering was not acceptable to many patients, particularly in communities with large First Nations populations.

> *... Because we have lots of issues with rostered and non-rostered. So, for example, our First Nations Populations politically don't want to roster. And there are issues around rostering with the government agency. We're trying to work through that, and so we still provide services to those non-rostered patients . . . rostered and non-rostered is really an unclear issue for our service models because of the Aboriginal contracts with the Family Health Team.*

3.1.5. Individuality of Family Health Teams

Most respondents emphasized how each team would be different, and that it would be difficult to generalize from one to the next. Some commented on how the "generic" question guide didn't fit their situation very well. In addition to the community characteristics, the history of the FHT, the professional composition of the FHT, the local supply of services, and the individual experiences and interests of providers were influences on the services provided by FHTs.

> *Because each family health team is built on the premise to try and meet local needs . . . I guess I think we're unique, 'cause it feels unique and special to be able to have that opportunity to help in those areas, but that's the mandate for all family health teams. It's to try to reach their particular target and populations and demographics, and to meet those particular health needs. So, in that sense, I guess we're all kind of special...*

3.2 Integration of Mental Health Services

The second part of the interview focused specifically on mental health services, including in-house (or on-site) mental health capacity, the role of primary care providers compared with specialists in mental health service delivery, and access to and integration of psychiatric services. One theme that emerged during the interviews was the mental health "niche" that FHTs could occupy within the broader range of community mental health services.

3.2.1. Mental health providers

Eight of the 14 FHTs had at least one social worker or mental health counsellor on staff at the time of the interviews. Four FHTs offered visiting clinics related to mental health, including adult mental health, methadone treatment, and dementia clinics. And, one FHT had a visiting mental health specialist. A total of 10 FHTs offered some form of mental health service, with the majority being offered on a full-time basis (Table 2).

None of the FHTs had employed a psychiatrist at the time of the interview, although one had been approved for a half-time position. Two FHTs reported having a visiting psychiatrist provide services at the FHT. Five FHTs had established access to telepsychiatry, resulting in 6 FHTs that could provide some on-site access to psychiatry for their patients. Three of these additionally reported having telephone support from a psychiatrist.

Despite the progress, some participants expressed the opinion that mental health had not yet been given sufficient attention by FHTs; this in part had to do with comfort or experience with mental health among FHT physicians and managers.

> *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!'

Table 2: Integration of Mental Health Providers with FHTs

FHTs with mental health services (non-psychiatric)	# of FHTs (n=14)	Cumulative # of FHT
At least one social worker	7	7
At least one CMHW/Counsellor	1	8
Visiting clinics	4	9
Visiting MH Specialist	1	10
FHTs with on-site psychiatrist services		
Visiting psychiatrist	2	2
Telepsychiatry	5	6
Telephone support to FHT from psychiatrist at referral centre	3	6

Visiting clinics: Visiting clinics for methadone treatment, dementia, and general mental health were reported.

3.2.2. Role of primary care providers

When asking about mental health capacity, interviewers often had to prompt the respondents to consider the primary care providers' role. With a few exceptions, the extent to which family physicians and nurse practitioners were involved in the provision of mental health care was described as limited, but usually included medication management and supportive care, referrals to internal or external specialists, and some limited counselling and education.

> [Prompted: The physicians' capacity], "*basic counselling I would think, especially the newer ones. And then just, medication review. But yeah, they don't tend to counsel if they can refer.*

In one exception, a physician was involved on a team supporting patients who had returned to the community with community treatment orders [i]. Again, there was great variation from team to team. In one case where the FHT had a vacant social worker position, some of the primary care providers played a larger role; at another FHT, a social worker described how the other team members stepped in if a patient was not comfortable with her. One FHT had a family physician with specialized training and interest in psychotherapy, but the physician did not provide that type of care within the FHT because of the physician payment mechanism. The FHT was interested in exploring the possibility of adding a salaried GP-psychotherapy physician position to the FHT.

3.2.3. Role of social workers and community mental health workers

Among the FHTs with a social worker or community mental health worker dedicated to mental health services, available services minimally included counselling, assessment, referrals, and crisis intervention. Depending on the number of FTE positions, some of these focused on assessment and referral, or even the very time-consuming case management and/or "system navigation." Some discussed the need to keep their roles focused as a coping strategy, to avoid being overwhelmed by high demand.

The role that a social worker or counsellor played on the FHT was determined to some extent by the availability of other professionals on the team, as well as the mental health service "niche" that the FHT was filling within the community; this will be explored in greater detail below.

[i] A community treatment order (CTO) is "an order that a physician signs that allows a person to have community-based treatment or care and supervision instead of being in the hospital. It is less restrictive than being in hospital . . . A CTO can only be signed or renewed for someone with serious mental illness when the conditions in the Mental Health Act are met".[22] For more information, see the Ontario Ministry of Health and Long-Term Care website, http://www.health.gov.on.ca/english/public/pub/mental/faq.html.

3.2.4. Mental health "niche"

One unprompted theme emerged at various points during the interviews. Most respondents wanted to consider what mental health service "niche" their FHT could or should fill within the broader constellation of community mental health services, based on the types of services provided in relation to other services provided in the community. Three approaches to defining a niche were identified: "everything else," "alternative choice," and "specialist" approaches. These three niches were not necessarily planned or mutually exclusive.

"Everything else." Some of the FHTs expressed concern over how their mental health services might fit among other services, expressing a strong desire to avoid "duplication of services." The result could be that FHT mental health provider was left to fill in the gaps in services left by the other community providers, and some found the lack of focus to be challenging, or even professionally unsatisfying.

> *We try not to duplicate services.*

> *I get everything that doesn't fit into their narrow mandate . . . which is really overwhelming… and frustrating at times.*

"Alternative choice." In a couple of cases, there was a view that a single service provider might not meet the needs of all eligible clients, and although it might be seen as stepping on someone else's turf, "duplication" was re-framed as increasing patient choice, and ultimately improving the acceptability and accessibility of mental health services. This was also reported by one of the FHTs that had not yet integrated with any mental health service.

> *…it's actually a fairly tense system right now between the family health team and the [external] mental health providers… Oh, the patients will not go there now that they have an option.*

> *What we found of late, there's a certain stigma... If people can get service, sort of in the same place that they go to, rather than us saying, "Oh, well, why don't you go visit Community Mental Health program, they're right across the parking lot." There's a stigma to that. One of the things that we're trying to do within our family health team is almost one stop shopping . . .*

"FHT Specialist." A third approach to defining their niche within mental health services was to develop expertise in a specialist niche of mental health care, consistent with the primary health care mission of family health teams. In most cases, this specialization was on the psychosocial aspects of health promotion, disease prevention, and chronic disease management.

> *Yes, and so I've gone through different kinds of evolutions of trying to kind of look at my mandate, and my scope . . . You know, kind of "What's truest to my role as a social worker within the family health team setting?" . . . So it's been a work in progress and it will probably continue to be . . .*

> *I [meet] with patients referred by the family physicians or a member of the Family Health Team. And we will work on issues related to diabetes management, hypertension, depression, anxiety, some chronic pain . . . all coming from a mental health perspective.*

In summary, the mental health services that are offered by FHTs appear to be somewhat delimited by existing community mental health services, with FHTs channeling patients to other services, as well as playing the "safety net" role to cover those left out by other mandates. This approach to rationalizing services relies on good collaboration and coordination between service organizations, which was not always the reality, and may not always be the preference of patients. Some FHTs saw the benefits of offering patients an alternative to the existing services, as well as offering "one stop" comprehensive services to reduce stigma. Finally, some FHTs were further along in developing specialized programming that integrated the psychosocial aspects of primary health care, providing the opportunity for mental health workers to play a key role and carve out their own specialist niche.

3.3 Integration of Psychiatrists

3.3.1. Awareness of psychiatric outreach services

FHTs were asked about whether they were aware of any psychiatrists who provided outreach services in their community, and whether or not consultants were affiliated with OPOP. Ten FHTs reported awareness of 13 visiting psychiatrists or psychiatric outreach consultants in their communities for adult mental health services. Prior to the survey, none had been familiar with the name "Ontario Psychiatric Outreach Program." A few participants could name programs, (e.g. North of Superior Programs (NOSP), North East Mental Health Centre (NEMHC), and Northern Ontario Francophone Psychiatric Program (NOFPP)). The majority were not sure about the program affiliation, but often knew which city the psychiatrist was based in. On the other hand, the home location of visiting psychiatrists through the North of Superior Programs (NOSP) was unknown. One FHT in an OPOP-serviced community that reported no visiting psychiatrist was providing services at the time of the survey, but indicated knowledge of past and future plans for a visiting psychiatrist.

3.3.2. Availability, accessibility, and utilization

Ten of the 14 FHTs had at least one type of psychiatric service available through the FHT. Two offered on-site access to visiting psychiatrists. Five reported having telepsychiatry services available, but only three reported telephone support from a psychiatrist at the nearest referral centre (Table 3). All of the FHTs that reported on-site psychiatric services reported having at least two of these modes of service delivery.

Referral to a visiting psychiatrist elsewhere in the community was available to 6 FHTs; five FHTs also reported that a visiting psychiatrist provided services within the community, but referral was effectively not an option; for two of these, no other psychiatrist service available. Limitations based on program focus or other eligibility constraints meant that FHT informants did not consider these services generally accessible to their clients.

Four FHTs reported no integration with psychiatric services. In addition to the two who could not access a visiting psychiatrist, one had a psychiatrist available in the community, but had not utilized this service. Notably, only one FHT reported having no psychiatrist available by any means.

Table 3. Integration of Psychiatrists with FHTs

Integration with Psychiatry – Mode of Integration	# of FHTs (n=10)
On-Site Services	
Visiting Psychiatrist at FHT	2
Telepsychiatry at FHT	5
Telephone support to FHT	3
Off-site Services	
Refer to visiting psychiatrist in community	6
Not integrated – Reason	**# of FHTs (n=4)**
No psychiatrist available	1
Psychiatrist in community - accessible but not utilized	1
Visiting psychiatrist in community - available but not accessible	2 [a]

[a] FHTs could report more than mode of integration or reason for no integration. A total of 5 FHTs reported that a visiting psychiatrist was available in the community but not accessible to the FHT. Because three of these reported alternative access to psychiatry, only two remained as not integrated.

3.3.3. Perceived Access

Services may be nominally available but not readily accessible, or utilized even when accessible. Whether or not a service is perceived as "accessible" is a factor associated with its use. Despite the reported availability of psychiatric services to 10 of the FHTs, the limited frequency of availability and other barriers meant that perceived access to psychiatrists was more limited than the above numbers suggest.

No regular and ready access. Although only one FHT had no available psychiatric services within the community, eight reported no "regular and ready" or "effective" access to psychiatry. So, for seven FHTs, services were available but there were perceived access barriers. Often, long waiting lists (including for telepsychiatry consultations), program barriers, or the

inability to have direct contact with a psychiatrist resulted in a perception of limited accessibility. One FHT expressed the desire to be able to use sessional funds to pay for a telephone consultation with a psychiatrist.

> *So they've kind of eliminated a lot of referrals. And we can't talk to them. They will not respond. They send us back to the gatekeeper again . . . We don't have access to psychiatry, which is a huge issue for myself, as I am left as the sole [mental health provider] . . . We have a visiting psychiatrist who will come but we never know when because we're not part of that system. It's a gatekeeping thing. So we're out of the loop completely.*

> *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 . . . But, in the time that I've been here, I've seen the time frame for the [telepsychiatry] referral … get really bogged down and long. Longer than what would be in the best interest of timely patient care.*

Accessible but not utilized. Two FHTs acknowledged that they might have access to a psychiatrist, but did not make use of that availability. In one case it appeared that the FHT had not yet developed any mental health programming. In the other, the lack of an established "system" meant that contact with a psychiatrist was restricted to particular cases.

> *No. Now, again, that's ah... a difficult question to answer. We don't utilize the services of a psychiatrist. However there is regular and ready access if we need it . . .*

Regular and ready access. Only four FHTs reported having "regular and ready access" to a psychiatrist; this included all three who reported having telephone access to a psychiatrist at a referral centre.

> *Yes. Well, with our two visiting specialists [psychiatrists], 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.*

Shared care. Two FHTs in particular were enthusiastic about their interactions with psychiatrists, describing their arrangements as "shared care." In one case, the arrangement was with a psychiatrist at the referral centre, with nearly all interaction occurring via videoconference. The other FHT had a visiting psychiatrist providing on-site services with an emphasis on indirect care, where the entire team met regularly with the visiting psychiatrist for case review and informal education. In contrast, one FHT that had on-site services from a visiting psychiatrist described a traditional visiting specialist / parallel practice model. The cases showed that (1) on-site services were no guarantee of the development of a "shared care" practice, and (2) a shared care via telepsychiatry was also possible.

> *Certainly, [the psychiatrist] who's in REFERRAL CENTRE, and who also does our telehealth... The doctors are able to contact [the psychiatrist]. And I can always contact {the psychiatrist] too . . . [The psychiatrist] is always available... always calls back . . . [The psychiatrist] has been [here] once to visit and take part in and do an education day with people, that was really great. [The psychiatrist] has a nurse on their outpatient team that's very accessible, and very easy to organize things with. I sit in on most of the interviews that we do with the patients, and [the psychiatrist] is really great about that. Yeah, it's a real shared care model. It works very well.*

3.3.4. Barriers to integration

Wait times. All of the FHTs reported some barriers to psychiatric referral. From the family health team perspective, wait times for referrals to psychiatry was the most significant barrier to a successful referral (12 FHTs). Some FHTs distinguished between wait times for urgent vs. non-urgent care, but differed on which was more problematic. One FHT reported increasing wait times for telepsychiatry referrals as well, but nonetheless reported faster access through their telepsychiatry service than through the visiting psychiatrist service in the community. Some reported

that wait times contributed to patients' unwillingness to be referred.

Program barriers and eligibility restrictions. In addition to wait times, program-related barriers and/or eligibility restrictions (e.g. SMI, age criteria) were significant barriers to accessing the services of visiting psychiatrists affiliated with other organizations in the community.

> *Now there is a psychiatrist that comes down with PROGRAM, but he really belongs to that PROGRAM, you have to have a worker at PROGRAM, you have to go through all of PROGRAM's intake, so there's a lot of rigmarole there... The client has to jump through quite a few hoops, just to get seen.*

A small number of FHTs reported other barriers, such as a lack of sub-speciality psychiatry (e.g. geriatric psychiatry), or lack of French-language services in their community. Finally, some FHTs spoke of the "root cause" of the barriers, an overall inadequate supply of psychiatrists.

Barriers to inpatient services/ distant referral centres. Family Health Teams varied in their perceived need for access to psychiatry, however the more remote the community, the greater the problems resulting from distance to inpatient services. One common challenge was transportation. Another was the resulting absence of family and friends when the patient had to leave the community, resulting in a heightened importance placed on keeping the patient within the community, rather than "forming" a patient (physicians complete a "Form 1" when sending a patient to a psychiatric inpatient facility for assessment).[23]

> *…but it has to be pretty extreme to form [a patient]… locums will come here and say, "Well, does this person need hospitalization?" And you'll look at the locum out of the corner of your eye and go 'What? Just don't!' We do everything we can to keep people here. We don't make use of a psych facility because, that's [a long drive] away from their families.*

Distance from tertiary-level services. Surprisingly, few FHTs reported the lack of psychiatrists in the community as a barrier. Some seemed to find it acceptable that there might be a need to travel, but instead found wait times and the lack of transportation to be the primary barriers to using those distant services. With one exception, no FHT was located in a community with a Schedule 1 facility (mainly the result of excluding the five northern urban referral centres (NURCs) from the study). Of the remaining 13 FHTs, eight were located within two hours, and five were between two and five hours. With one exception, respondents were familiar with the location of the nearest inpatient facility.

The nearest Schedule 1 facility was not always the established referral relationship however, and jurisdictional issues could cause some confusion.

> *Because of where we're located ... is that we technically are in [REGION-A], but, our closest proximity and our affiliation to hospital is in the [REGION-B]. So... who does what is still extremely unclear . . . when we try to get some clarification on who's responsible for our area, even the services themselves find it difficult to decide whether they are responsible for our area or not.* [Describes an incident where services in neither REGION would accept a referral]. *And yet we went through [REGION-A], initially we were told that they didn't serve us. And then it was really up in the air whether they served us. And then it ended up they didn't have any psychiatrists anyways so it was a moot point . . . And this is not new. I've been here for years and it's still, we're still struggling over the same boundary issues.*

Transportation issues were considered the second most significant barrier, reported by 11 FHTs, followed by patients unwilling to accept referrals (6 FHTs), often described as related to the first two barriers. An equal number reported either no psychiatrist accepting referrals, or a psychiatrist accepting only specific types of referrals as a major barrier. Related barriers reported included no available beds at the referral facility, and eligibility criteria.

3.3.5. Continuity of care

Whether delivered via outreach or at a referral centre, several FHTs were concerned about lack of continuity and consistency of psychiatric care. In some cases, this was related to turnover of psychiatrists. But most were related to the fact that visiting and referral centre psychiatrists were different physicians.

> *[The doctors] find that if somebody sees one psychiatrist, and then they see another psychiatrist, and then they see another… then their medications are always getting changed, because it depends more, it seems to be about the psychiatrists' favourite medications. So, that's very frustrating on them...*

3.4 Education and Training Needs

3.4.1. Informal education

Although the majority of respondents interpreted the question on education and training as pertaining to formal education models, a small number of FHTs reported case review as one mode of sharing patient information after a referral, and informal education was recognized as a benefit of case review:

> *Yes, [education and training] is done informally with the visiting psychiatrist, with Dr. X. Remember how I said we spend an hour and a half at lunch where we do case review, or follow up on patients that he might have seen? But it has been extremely useful because we've all learned something new as a result of that kind of informal, ahh, consultation if you want to call it that.*

3.4.2. Formal education

Informants were asked if any members of their family health team had attended any education or training sessions on mental health in the previous year. Slightly more than half (8) reported that at least one team member had attended at least one training session (usually, the participants themselves). Only two FHTs reported family physicians attending mental health education or training, although a number of participants admitted that they did not know about physicians' training activities. Two FHTs reported multiple staff attending training; these teams were also those that were most vocal about their strong interdisciplinary team orientation. In most cases, a single member of the team had attended two or more more training sessions; this was the FHT provider whose job was most focused on mental health (e.g. social worker, mental health worker).

> *Well the answer would be just myself. The social worker. And I don't believe that mental health training here has been a high priority for anyone else, since the Ministry of Long Term Care has been putting colorectal screening and diabetes as its top priorities for training.*

Topics of training sessions attended over the past year varied widely, and could be broadly classified as focusing on a specific condition (e.g., anxiety, tobacco cessation, depression), a treatment modality (e.g., cognitive based therapy, motivational interviewing, mindfulness based approaches, solution-focused therapy), or a special population (e.g. seniors). Attendance at a shared care conference was also reported.

3.4.3. Preferred education/training modality

Informants were also asked about their preference on various means of obtaining further training or education on mental health issues. A slight majority (8/14) preferred modalities that allowed them to remain within their community – on-site training or distance education (e.g. web-based or online courses; training delivered via video conferencing).

Most indicated a strong preference for on-site training; however, just as many were reluctant to voice that preference, viewing it as unrealistic. A perceived lack of "critical mass" for on-site training discouraged some from considering on-site training as a viable option. Distance-based modalities were not necessarily the preferred mode but were nonetheless acceptable to most FHTs, *if the technology was available.* In some cases, the high-tech glamour of videoconferencing was seen as having an added appeal for particular audiences (e.g. physicians). Web-based courses were slightly less preferred than videoconferencing; however, all of the FHTs had access to high-speed internet, whereas some did not have access to videoconferencing. Among the FHTs expressing a strong team orientation, the ability for the entire team to receive the same training was particularly important.

In addition to the benefits of having training available on site, a small number commented on the benefits of offering training at the community level - being able to involve multiple providers from different organizations in the same training.

> *Another, it's something that I use to use a lot, is for awhile, the outreach program for psychiatry, did about once a month. A little mini-conference on different [topics] ... if we could access through the hospital, or through other agencies, you know, some type of program where more than.... You can regroup the mental health people in training like that. I do access, sometimes, some training, along with the other agencies...*

Many informants expressed the idea that training preferences would vary from person to person, and not all desired on-site or community-based training. A minority preferred training that required travel, e.g. attending conferences, short courses or workshops, although it was not always easy to find the support to do so. This interest or willingness to travel was linked in part to interest in longer-term training (e.g. 6 months, experiential training with a mentor), less common training topics or issues, or again, a perception that no one else at the FHT or in the community would be interested.

> *Geriatric psychiatry, dementia is another field that... I'm talking about personal interest here. Because I'm the only person here, you know? So this is my clientele.*

3.4.4. Topics of interest for future training

Finally, informants were asked what mental health topics would be interesting and useful for their FHT. All informants listed at least three topics, some as many as six, with a total of 24 topics identified. FHTs without any dedicated mental health provider tended to identify topics of broader interest or that affect most communities, whereas informants who were themselves mental health providers tended to request topics that were specific to their particular practice needs.

The three most frequently mentioned topics were anxiety, depression and other mood disorders, and seniors' mental health. These were followed by personality disorders, and the mental health aspects of chronic disease management. Other topics of interest included prescription of psychotropic drugs and medication management, management of psychosis and schizophrenia (including management of patients' daily lives in the community), addictions and substance abuse, children's mental health, and stress management.

> *... training on initially dealing with mental health problems as they relate to their chronic disease management. And it's based on how we're trying to run our chronic disease management programs. For instance, the hypertensive management program isn't just dealing with somebody's high blood pressure. It's assessing... ahh treating life style changes, exercise, nutrition, behavioural changes, smoking cessation. So they become all part and parcel. And we're realizing now that mental health is a huge component of that.*

A number of participants identified topics for training and education that were related to the gaps they perceived in local mental health services, a gap that the FHT could see itself as filling while not "duplicating" the services of other mental health organizations in the community. While services were often available for "serious mental illness," they were less likely to be available for "less serious" mental health needs of adults and children. As well, the need to integrate concepts from traditional aboriginal healing was reported.

> *And I know mood disorders would not necessarily fit the criteria of adult mental health services getting involved. And so that's left kind of more in our department here.*

4. SUMMARY AND CONCLUSIONS

FHT Membership and Practice Characteristics

FHTs in this sample varied greatly in terms of size, team composition, and spatial organization, as well as length of time since beginning operation as a family health team. For example, the number of FP/GPs per FHT ranged from 0-14, with a mean of 4.75 FTEs. Pre-FHT history and relationships appeared to have a greater influence on the FHT than the length of time since incorporation. Many emphasized that they were still in the early stages of development; others emphasized the uniqueness or individuality of FHTs, and the hazard of generalizing from one FHT to another.

Despite the Ministry of Health and Long-Term Care's description of Family Health Teams as inclusive of physicians, not all FHTs considered the physician group to be part of the FHT. This was related to the fact that physicians were not "employees" or paid by the FHT, but incorporated as a separate physician group. Respondents often had to be prompted to include the physicians' perspective in their responses, and some stated they could not. However, this distinction was not relevant to all participants. Future research on FHTs should be aware that some FHTs make this distinction, and explore the implications for team-based and collaborative practice.

Limitations on northern FHT development. Because funding for interdisciplinary providers is linked to the number of enrolled (or rostered) patients, FHTs in the north faced disadvantages to growth and development. Shortages of family physicians were seen as the primary limiting factor on FHT development, as enrolment was dependent on the number of physicians. Four FHTs had a combined seven vacancies at the time of the interview. A related frustration was that nurse practitioners were not allowed to roster patients.

The second challenge was community attitudes toward enrolment; resistance to rostering was a particular challenge in communities with large First Nations populations. As a result, some FHTs struggled to meet the needs of their communities. Unrostered patients frequently had no choice but to continue seeking care at hospital emergency departments. Limitations on patient enrolment translated into difficulty obtaining approval for new positions. Many positions had been approved on a part-time basis only; the majority of vacancies on FHTs were for part-time positions, which were even more difficult to fill than full-time positions.

The above are examples of how a global factor (funding model) can have differential effects on FHTs when interacting with local factors (provider supply, geography, population characteristics, as described by Mulvale and Bourgeault (2007).[19] These issues suggest the need to consider alternatives for funding interdisciplinary providers in the north.

Integration of Mental Health Services

At the time of the survey, slightly more than half of the participating FHTs had a dedicated mental health professional on staff, and 10 of the 14 had integrated some degree of mental health service within the FHT. With a few exceptions, family physicians and nurse practitioners were seen as playing a primarily supportive role with regard to mental health services, usually preferring to refer to specialists. Eight of the FHTs had added at least one mental health professional (social worker, community mental health worker) to the interdisciplinary team, who provided counselling, assessment, and referral and system navigation services.

However, nearly half of the FHTs had not yet hired any mental health staff; this did not appear to be related to the length of time since beginning FHT operation. There was no apparent association between integration of mental health services with the age or size of the FHT. According to some informants, this depended more on level of comfort with mental health care of the FHT managers / administrators, as well as the family physicians. It was also seen as a consequence of FHTs' (medical) focus on chronic disease priorities. Some also saw mental health as an "add on" rather than a core service. To increase the integration of mental health care, mental health should be identified as a core service and labelled a priority.

Niche within mental health services. Mental health providers within FHTs struggled to find a niche within the constellation of community mental health services. A majority were concerned that they "not duplicate services" of other mental health organizations, and tried to provide "everything else" not covered by others' mandates. In contrast, a minority rejected "duplication" as a problem, endorsing the view that they were increasing accessibility, patient choice, and providing a one-stop integrated service, consistent with the FHT mission of patient-centered care. A third group was attempting to further specialize in mental health services specific to the primary care mission of the FHT, such as the psychosocial aspects of health promotion, disease prevention, and chronic disease management.

These varied approaches to finding a niche revealed a perceived tension between a desire to maximize resources by avoiding duplication, and the FHT mandate to provide patient-centred services. Negotiating this tension may be a unique challenge for FHTs in rural and remote Ontario; Mulvale et al. (2008) reported the same concern for "working with existing services and not duplicating them" among rural FHTs, but not urban FHTs.[20] Although the language reflects an ideology of economic efficiency and rationalization, this concern was also about respecting other professionals' "turf" and mandates. Indeed, a number of the social workers/counsellors currently working for FHTs had previously worked for these other agencies, suggesting a possible reason for heightened sensitivity to turf issues. The struggle to define a mental health service niche warrants further attention to the local service environment (context), as well as to funding and accountability structures. It further suggests that as the FHT model develops, FHTs may benefit from further guidance on the role of mental health workers within the FHT and in relation to other community mental health services.

Integration of Psychiatrists

A strong ethic of keeping patients in the community was also expressed, reinforcing the need for local access to the services provided by psychiatrists, in addition to those provided by other mental health professionals. Ten FHTs reported awareness of a psychiatric outreach consultant or visiting psychiatrist in the community and two reported on-site services. References to psychiatrists are not necessarily OPOP-affiliated psychiatrists. Although half of the FHTs were located in communities that received OPOP-affiliated outreach services, none were familiar with the "Ontario Psychiatric Outreach Program" name prior to the survey. OPOP programs may benefit from increasing communication and visibility within such communities.

Ten FHTs reported the integration of at least one mode of psychiatric service delivery which enabled them to provide some care within the community. Six FHTs offered on-site services through a combination of visiting psychiatrists, telepsychiatry, and/or telephone support from a psychiatrist for indirect care. Six FHTs were also able to refer to a visiting psychiatrist within the community. Only two reported visiting psychiatrists providing services onsite; another two reported telephone support from psychiatrists at the nearest referral centre. Two FHTs described their model of psychiatric service delivery as "shared care" (one with a referral centre psychiatrist via telepsychiatry, one with on-site services from a visiting psychiatrist).

Despite the availability of various modes of psychiatric service delivery, only four FHTs reported having regular and ready access to a psychiatrist. Five FHTs reported having a visiting psychiatrist within the community whose services were not easily accessible to the FHT staff or patients. Perceived barriers to psychiatric services in the community were long waiting lists, program eligibility restrictions or provider-based criteria (e.g. psychiatric subspecialities), and the inability to directly contact a psychiatrist when needed. Availability of telephone support from a psychiatrist was key to the perception of good access.

Continuity of care. A minority of FHTs voiced frustration over frequent changes to care plans that result when a patient saw a different psychiatrist at each visit or service site. While in some cases there could be multiple visiting psychiatrists, or turnover in visiting psychiatrists, the main concern was over inconsistencies in recommended or prescribed treatments between visiting psychiatrists and referral centre psychiatrists. FHTs expressed a strong desire for having a consistent relationship with one or two psychiatrists. OPOP and other visiting psychiatrists may see improved effectiveness of their service if they establish relationships with psychiatrists at the northern urban

referral centres. Although this was not a global concern in this sample, the fact that the issue was unprompted and raised by multiple FHTs suggests the need for further investigation.

Education and Training Needs

A majority of FHTs preferred education/training modalities that allowed them to remain in the community. Although most agreed that on-site training would be the most useful, it was viewed as "unrealistic." Participants were accustomed to distance-based modalities (internet, videoconference) and found them acceptable. Some preferred having training accessible to the entire FHT or other professionals within the community, to enhance team practice and community collaboration. For others, lack of a "critical mass" was a barrier to attracting in-community opportunities. Several participants expressed doubt about other team or community members being interested in the same training, and many reported that mental health training was not a high priority among other FHT staff.

The topics of interest most frequently cited were anxiety, depression and other mood disorders, and senior's mental health, followed by personality disorders, and the mental health aspects of chronic disease management. These were related to perceived gaps in services in the community, often the types of conditions not covered by other organizations with mandates restricted to services for persons with SMI. Other topics were unique to the FHT mandate. FHTs represent a largely untapped audience for interdisciplinary mental health care education and training programs, with a focus on primary mental health care and the psychosocial aspects of chronic disease management. "Traditional" topics remain important, particularly for disorders or conditions not covered by services for persons with SMI.

Next Steps

This study is the third component of a larger study. Two other components focused on the practices of psychiatric outreach consultants; of particular interest is the ability to compare perspectives on each side of the primary care-secondary care interface, particularly on the topic of shared care. A planned comparative analysis will focus on patterns of interactions between psychiatrists and primary care providers in smaller northern communities. A final study component consists of community case studies that examine the integration of mental health services from the community perspective. Synthesis of all study components will provide multiple points of data to examine specific themes from multiple perspectives.

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APPENDIX A: LIST OF ACRONYMS

CAMH	Centre for Addiction and Mental Health
CCMHI	Canadian Collaborative Mental Health Initiative
CME	Continuing Medical Education
CMHW	Community Mental Health Worker
CRaNHR	Centre for Rural and Northern Health Research
CTO	Community Treatment Order
ECP	Extended Campus Program
FHT	Family Health Team
FHN	Family Health Network
FTE	Full-time Equivalent
FP	Family Physician
FRCPC	Fellow of the Royal College of Physicians and Surgeons of Canada
GP	General Practitioner
LHIN	Local Health Integration Network
MOHLTC	Ontario Ministry of Health and Long-Term Care
NE LHIN	North East Local Health Integration Network
NW LHIN	North West Local Health Integration Network
NOFPP	Northern Ontario Francophone Psychiatric Program
NOSP	North of Superior Programs
NP	Nurse Practitioner
NPOP-C	Northern Psychiatric Outreach Program at the Centre for Addiction and Mental Health
NURC	Northern Urban Referral Centre (North Bay, Sault Ste. Marie, Sudbury, Thunder Bay, and Timmins)
OB/GYN	Obstetrician/Gynecologist
OPOP	Ontario Psychiatric Outreach Program
PCP	Primary Care Provider (family physician, general practitioner, nurse practitioner)
PHC	Primary Health Care
RN	Registered Nurse
RPN	Registered Practical Nurse
SMI	Serious Mental Illness
UAP	Underserviced Areas Program
UWO	University of Western Ontario

APPENDIX B: Interprofessional Providers

Number of full-time equivalent (FTE) positions filled or vacant, and number of FHTs with funded positions filled or vacant, at the time of the interview.

	STAFFED POSITIONS		VACANCIES	
POSITION	**NUMBER OF POSITIONS FILLED (FTE)**	**NUMBER OF FHTs with AT LEAST ONE PROVIDER (n=14)**	**NUMBER OF VACANT POSITIONS (FTE)**	**NUMBER OF FHTs with VACANCIES (n=14)**
Administrative/Coordinator/Support	28.5	13	0	0
Nurse Practitioner (NP)	20.5	13	†5	4
Registered Nurse (RN)	16.5	11	7	4
Registered Practical Nurse (RPN)	14.5	7	0	0
Social Worker	6.5	7	1.5	3
Dietician/Nutritionist	5	7	2.5	4
Pharmacist	3.25	6	.7	2
Chirapodist	1.2	2	.25	1
RN/Chronic Disease Manager	1	1	1	1
Health Systems Navigator	1	1	0	0
Community Mental Health Worker (CMHW)/Counsellor	1	1	.5	1
Respiratory Tech / Therapist	0.5	1	.5	1
Epidemiologist	0.5	1	0	0
Physician Assistant	0.3	1	0	0
Case Manager	0	0	1	1
Health Educator	0	0	1	1

Filled: Employed at the time of the interview.
Vacant: FHT had obtained funding for the position, however the position was unfilled at the time of the interview.
None of the following provider types were reported: Aboriginal health worker; addictions counsellor; chiropractor; occupational therapist; psychologist/psychological associate; social service worker. Two midwife positions had been requested but not yet approved.
† One NP position was filled, however, the NP was away in training for the year, thus counted here as vacant.