Mental Health Services in Smaller Northern Ontario Communities:

A Survey of Psychiatric Outreach Consultants

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Main Messages

A mixed methods survey of 25 psychiatrists was conducted in the winter of 2008-2009, to document models of psychiatric outreach used in northern Ontario, and to identify opportunities for enhancing services provided through the Ontario Psychiatric Outreach Program (OPOP). Key findings were:

- Individual outreach practices evolved over time and were influenced by historical differences among program partners, mental health reform, and the development of community mental health services. The studies indicated that no single "model" was used by OPOP consultants, as models developed to fit the varied needs and capacities of northern communities, as well as individual consultant constraints and interests.

- Although there were some cases where consultants had successfully enacted change to improve their individual model, consultants generally viewed outreach as needing to be responsive to community needs and interests, and the preferences of the community shaped the outreach model.

- Most OPOP consultants provide outreach services in a secondary or specialist setting, with the majority of outreach consultations occurring in a hospital or a community mental health centre, and most collaboration occurring with community mental health service providers.

- About one out of five consultants appeared to have regular interaction with a primary care physician. Written communication was the most common form of communication between consultants and family physicians/general practitioners (FP/GPs), with face-to-face interaction being relatively rare. Reported barriers to increasing collaboration at the primary care level were shortages of FPs/GPs, combined with limited interest in collaborating among some FP/GPs.

- Most outreach consultants preferred an indirect care (consultation) model over a direct care model, although both were needed, particularly where FP/GPs were scarce.

- A majority (83%) of survey participants reported providing some between-visit support in the form of telephone or email backup. However, focus group participants suggested that these components should be implemented more systematically, including telepsychiatry. Some consultants faced institutional barriers to providing linkage functions and between-visit support services.

- A small number reported formal education activities as a significant component of their practice. While some recommended increasing the educational component of outreach, others reported a number of barriers to increasing education activities. The most common barrier reported was lack of interest at the community level.

- Consultants based in a northern urban referral centre (NURC) were more likely to interact with FP/GPs, and more likely to report linkages with tertiary services. These findings support the notion that the outreach geography influences the outreach model.

- The University of Western Ontario's Extended Campus Program was recognized as a critical factor in a northern district's ability to recruit and retain psychiatrists. Without OPOP outreach services to other northern districts, they would overburdened.

- Both OPOP and non-OPOP psychiatrists agreed that coordination between outreach consultants and referral centre psychiatrists could be improved; however, there were limitations on regional referral services that needed improvement before such efforts would be effective.

- Suggestions for model enhancement included the development of multidisciplinary outreach teams, and the development of an on-call multidisciplinary resource that would include subspecialists in psychiatry. This would enable the visiting consultants to expand their services they provide in their outreach communities. Northern-based psychiatrists also desired support from psychiatric subspecialists.

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Executive Summary

Research design.   Following a literature review of models of psychiatric outreach, a mixed methods survey of psychiatric outreach consultants was conducted. A multi-mode survey was designed to examine existing models of service delivery used by psychiatric outreach consultants. A total of 27 questionnaires on outreach practices were completed by 25 consultants between October 2008 and February 2009; the majority were affiliated with the Ontario Psychiatric Program (OPOP). In addition, two focus group discussions were conducted in Fall 2008, one with OPOP-affiliated consultants, and one with a combination of northern-based psychiatric outreach consultants (with and without an OPOP outreach program affiliation), and some OPOP administrators. Topics of discussion centred on five themes: The service delivery setting, challenges in the outreach practice, collaboration and teamwork, linkages with tertiary care centres, and enhancing the OPOP model.

What is the 'OPOP model' of psychiatric outreach? Given the degree of variation in responses and reported patterns, it is difficult to generalize about a single model. Moreover, consultants indicate mixed patterns within a given outreach practice.   Focus group participants indicated that there was no single "model," but rather multiple models that fit the varied needs and capacities of northern communities, as well as individual consultant preferences and constraints. Community providers are strong influences on the form and functions of the outreach model.   Individual outreach practices evolved over time and were affected in part by historical differences among program partners, mental health reform, and the development of community mental health services. Although there were some cases where consultants had successfully enacted change to improve their "model", consultants generally viewed their model as responsive to community needs and interests; most tried to accommodate the preferences of the community.

For a majority of consultants, the main model appears to be a parallel model of outreach to the secondary level (hospitals and community mental health centres), rather than to the primary care level.   This model was multifaceted, similar to a consultation-liaison model of outreach to the primary care level, however, the psychiatrist had limited direct interaction with primary care providers, and most of the intervention elements involved community mental health workers and teams rather than primary care providers and teams. Most consultants reported high levels of collaboration and teamwork with community mental health providers. However, few reported team-based practice elements such as joint consultations or case conferences. In most communities, the community mental health providers were responsible for care coordination and service integration with family physicians and other care providers.

Although most outreach consultants provide some treatment, most appear to leave the ongoing care and management of the patient in the hands of community-based providers; this appears necessary because most consultants travel to their outreach communities less than once a month.   However, most consultants provided between-visit support by telephone or email, primarily to community mental health workers but also to family physicians. Although most consultants have conducted some education activities, a minority provide formal education services. Twice as much informal education occurs as does formal education. Consultant recommendations to enhance the model included more systematic between-visit support to outreach communities and more attention to education and capacity-building activities.

About one out of five OPOP consultants provided regular outreach services to the primary care level, more often to a community health centre setting than to a family practice.   For others, face-to-face interactions with FP/GPs appeared relatively rare; the main modes of communication with family physicians were written and

telephone communication. Service sites were rarely co-located with family practice clinics, limiting opportunities for informal contact. Because family physicians in rural and remote communities also provide emergency department and primary care coverage within hospitals, consultants working in hospitals could interact with family physicians outside of the usual "primary care" setting described in the literature; such interactions do not produce the community-based integration of mental health and primary care envisioned by shared care models.

Some consultants expressed a desire to work more collaboratively with FP/GPs, but reported a number of barriers to this collaboration. Barriers included a shortage of FP/GPs and community reliance on locums; payment mechanisms for family physicians that discouraged collaborative activities; and a lack of time and interest among some primary care physicians.

Other outreach models were also reported by consultants. These included consultant-liaison and shared care models with primary care; an itinerant model of outreach to multiple communities; and the Assertive Community Treatment (ACT) model. These models were more common among consultants whose program or home base was closer to the outreach communities (e.g. consultants based in a northern urban referral centre, or NURC), and whose proximity enabled more frequent visits and higher levels of interaction and support that would be indicated by those models.

There were some differences in the findings from the survey and the focus groups on the amount of direct clinical care. From the survey, most consultants appeared to be working in a traditional "visiting specialist" model, providing direct clinical care in a parallel or referral arrangement. In the focus groups, OPOP consultants emphasized their consultative function, rather than treatment. This difference may be due to the difference in the participant samples, or to the greater nuance and explanatory detail afforded to the focus group participants. In the focus groups, it became clear that "direct care" did not necessarily include primary responsibility for ongoing treatment of the patient, which would be the key difference between a treatment and a consultation model. Focus group participants indicated a preference for an indirect

consultation model over direct care treatment model, although both were needed to meet the needs of their patients. From the consultants' perspective, the main drawback of an indirect care model (consultation model) was the variable capacity of local providers to provide the needed care, particularly in communities where there were shortages of family physicians.

Linkages. In the focus groups, only the northern-based psychiatrists and one OPOP consultant indicated a linkage between their outreach practice and home-based practice. Consultants based in a NURC and providing outreach services within their service area were more likely to interact with family physicians, and more likely to report liaison functions. These findings support the notion that the outreach geography (distance from home practice to outreach practice) is an important factor in the model. A key benefit of the OPOP model was consultants' relative anonymity in the community, which appeared to reassure patients of confidentiality and increase the acceptability of psychiatric referrals.

Impacts on northern psychiatric services. Focus group participants recognized a number of positive impacts of the OPOP outreach beyond increasing community-based access to psychiatry in northern Ontario. NURC-based psychiatrists in particular commented on how the Extended Campus Program improved recruitment and retention of psychiatrists in the NURC, and capacity was now sufficient to cover the district with their own outreach services. However, local capacity would be overwhelmed without OPOP outreach services to other northern districts.

Recommendations for enhancement. From the consultants' perspective, a benefit of strengthening linkages between outreach providers and regional services would be improved support to visiting psychiatrists in the field, for enhanced range and quality of outreach services. Possibilities were discussed for model expansion centred on the improvement of multidisciplinary support, such as the development of multidisciplinary outreach teams (psychologists, psychiatric nurses, and nurse practitioners were the most desired disciplines for an outreach team), and/or development of an on-call resource of various disciplines

including subspecialists in psychiatry. Northern-based psychiatrists also desired this resource.

Conclusions. The finding that most consultants performed outreach services at the secondary level was surprising because models described in the literature focused almost exclusively on outreach to the primary health care sector; there were few cases of this model identified in the literature. This study will contribute to the scarce literature on models of psychiatric outreach to the community mental health sector.

One intriguing discrepancy was between consultants' perception of their outreach practices as being team-based and collaborative, yet a minority reported key elements associated with team-based collaborative practice, such as joint consultations. This discrepancy could be explained by a number of possibilities, including problems with the questionnaire; multiple and disparate understandings of "collaborative care", "team-based care", and "shared care"; and static models of collaboration that fail to adequately account for the dynamism and adaptive nature of collaborative practice.

Another possibility is that urban-based models of collaboration do not fit the rural and remote context, given, for example, reduced access to family physicians and other community-based providers with whom to collaborate. A number of related questions emerge: How would consultants explain these discrepancies? Is "collaboration" different in rural and remote practice than in urban practice? Do existing models of collaboration need to be revised to fit the rural and remote context, and if so, how? Given the policy focus on collaboration and shared care, it is important to "rural proof" these models.

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1.   CONTEXT

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 to provide clinical services through outreach, distance-based clinical and support services via telepsychiatry, and educational services to participating communities. It 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 also influenced the delivery of mental health services. As most mental health services are delivered in primary care, the recent development of *Ontario family health teams* has promoted the integration of mental health care with primary care. This is consistent with the expansion of "shared care" or "collaborative care" mental health services across Canada, in which there is collaboration between family physicians and mental health professionals. Another aspect is the recognition of the importance of *interdisciplinary care*, a team-based model designed to address comprehensive health care and improve access to mental health care despite specialist shortages. And, of particular relevance to mental health care for smaller communities in Northern Ontario, development of *telepsychiatry services* in recent years has enabled provision of consultative, direct and indirect patient care to rural and remote areas lacking ready access to mental health professionals.   Finally, the development of the Ontario *Local Health Integrated Networks (LHINs)* offers an opportunity to plan mental health services on a regional level, and consider population mental health needs in Northern Ontario.

In response to an external review[1], OPOP has partnered with the Centre for Rural and Northern Health Research (CRaNHR) at Laurentian University since early 2008 to conduct a research project to document the service delivery model(s) employed by OPOP.   The overall research approach was descriptive and comparative, employing a combination of quantitative and qualitative

methodologies to collect data from multiple perspectives and at multiple levels, from individual physicians, care delivery organizations, and communities.   The project consists of five study components: (1) a comprehensive literature review, (2) a survey of OPOP psychiatric outreach consultants, (3) focus groups with psychiatric outreach consultants, (4) a survey of mental health services in Family Health Teams, and (5) community case studies. Study results will be used by OPOP and its consultants to understand the mental health service delivery models employed by OPOP and other mental health service providers, and also inform the MOHLTC about the range and types of mental health services provided in smaller northern Ontario communities. The study is the first step towards the development of an evidence-based approach for planning and assessing services provided by OPOP.

This report presents results from the research components focusing on psychiatric outreach consultants. Following an extensive literature review, a survey and focus group discussions were planned to collect quantitative and qualitative data from psychiatrists providing outreach services in northern Ontario.   The main research questions were: "What model or models of psychiatric outreach are used by OPOP-affiliated consultants and what factors influence the model selection?" Data were collected in the fall and winter of 2008-2009.   The survey was designed to provide a snapshot of service provision, unmet needs, and interactions with other health service providers, as well as identify opportunities to enhance OPOP services.

1.1   Overview of The Ontario Psychiatric Outreach Program

The distribution of psychiatrists in Ontario can be characterized as concentrated in large population centres, especially those in southern Ontario. In contrast, even the larger cities in northern Ontario face chronic shortages of psychiatrists, and patients from rural and remote communities often must travel long distances to

obtain diagnosis and treatment. At the same time, rural residents often experience poorer physical and mental health status compared with their urban counterparts.[2,3,4,5]

To increase access to psychiatric services in rural and remote Ontario, the Ontario Psychiatric Outreach Program (OPOP) provide on-site services primarily through visiting specialist clinics, as well as urgent locum and telepsychiatry services.[6] OPOP is a consortium of programs affiliated to five academic health science centres and two partner programs that provide psychiatric services, clinical education, and support services.

- University of Ottawa Northern Ontario Francophone Psychiatric Program (NOFPP)
- Northern Psychiatric Outreach Program at the Centre for Addiction and Mental Health (NPOP-C) (formerly University of Toronto Psychiatric Outreach Program, UTPOP)
- University of Western Ontario Extended Campus Program (UWO-ECP)
- Queen's University Psychiatric Outreach Program
- McMaster University Psychiatric Outreach Program (James Bay)
- Northern Ontario School of Medicine (NOSM)
- Ontario Child and Youth Telepsychiatry Program

In addition to the delivery of clinical services, education has long played a central role in the various programs, through both formal and informal educational approaches. Informal education is one mechanism designed to increase capacity of local providers, and can be delivered by consultants through a range of approaches. Consultants may also be involved in supervising the training of residents, which is coordinated by university faculties of medicine. Psychiatry residents can complete a rotation or a short-term clinical experience in the north, often in a community-based setting. Residents from southern Ontario can either stay in northern communities for three or six months, or accompany consultants on their outreach trips, as part of their post-graduate residency.

History of OPOP. OPOP was created at the request of the Underserviced Areas Program (UAP) *"as an independent entity with a mandate to coordinate provincial psychiatric outreach clinical and educational service."*[7] The Western, Toronto and Ottawa programs pre-dated the creation of

OPOP as an umbrella organization, and have their own histories and missions. The UWO Extended Campus Program (ECP) was created in 1985 to address recruitment and retention of psychiatrists in underserviced areas. The University of Toronto Department of Psychiatry had long been involved in psychiatric outreach, beginning with the Sioux Lookout Zone since 1969 and Baffin Island since 1971.[8,9,10,11] The former University of Toronto Psychiatric Outreach Program (UTPOP) was established in 1994, and in 2010 was renamed the Northern Psychiatric Outreach Program (NPOP-C) at the Centre for Addiction and Mental Health (CAMH). The Northern Ontario Francophone Psychiatric Program (NOFPP) was established in 1981 at the University of Ottawa to provide services to Francophone communities in northeastern Ontario (See Appendix C for a map of OPOP-affiliated services in the North East and North West LHINs).

Since 2000, OPOP has been coordinating these independent programs through a steering committee and various subcommittees. The partnership between the UWO-ECP, NOFPP, and UTPOP has since developed to include partners at Queen's University, McMaster University, UT Division of Child Psychiatry (SickKids), and the Northern Ontario School of Medicine (NOSM). These programs continue to operate independently, even as OPOP strives to enhance services and improve coordination among the programs.[12] Because of the independent structures and administrations, it is difficult to document the OPOP "model" of service delivery. The application of the OPOP model of "clinical, support and educational services" may vary greatly between programs, providers, and communities.

1.2 Models of Psychiatric Outreach

Specialist outreach improves access to specialist care, and rural and disadvantaged populations may benefit the most from outreach.[13] The literature on psychiatric outreach models focuses on outreach to the primary care level, and models of psychiatric outreach can be classified based on the proposed relationship between primary and secondary care: *parallel models*, *referral models,* and *primary health care models.* These three classes vary on two normative dimensions: what role primary health care (PHC) providers (family physicians, general practitioners, some nurse practitioners) should perform in mental health care, and how primary and

secondary services should interact. In the parallel and the referral models, secondary (specialist) services are seen as the appropriate level for mental health care delivery, however they differ in that referral models focus on primary health care providers as gatekeepers and coordinators of patient care. Primary health care (PHC) models of outreach argue that most mental health care needs are, and should be, treated at the primary care level, reserving the services of scarce specialists for the most difficult cases.

With the rise of primary health care and a growing shortage of specialists in the 1970s, the role of family physicians in outreach models began to include the provision of mental health care, with models varying on the extent to which the primary care physician became responsible for mental health care. There is also an increase in emphasis on education and training for family physicians to allow them to provide treatment for common problems and to improve diagnostic capacity for more effective referrals.[14,15] Consultation, consultation-liaison, and shared care models share many of the same elements but differ in the degree to which the family physician or psychiatrist is responsible for patient care. [16,17,18,19,20]

Current literature is dominated by shared care models. Shared care as an ideal is partly predicated on a philosophy of improving quality of care through interprofessional collaboration. Shared care models emphasize three strategies: improving communication, building linkages between family physicians and psychiatrists, and integrating psychiatrists and psychiatric services in primary care settings.[19,21] Recent models have increased in complexity, and the model can be extended beyond the family physician and psychiatrist to include either a primary health care team or an outreach team to the primary care level.[22]

Some outreach models focus on developing linkages between outlying communities and proximate, referral-level services. Benefits include improved acceptability of referrals to patients and greater likelihood of a patient attending a referral appointment; better understanding of rural conditions among urban-based psychiatrists; and improved coordination and continuity of care between community and referral level services.[13,23,24,18,25,22]

Liaison functions can also take the form of between-visit support via email, telephone, or telepsychiatry.[26] The availability of backup makes primary care providers more willing to take on patients with mental health issues.[27] A study in Ontario showed that telephone backup to family physicians enabled them to handle mental health cases more effectively, and reduced the utilization of other mental health services.[28] In addition to improving triage, telephone support enabled timely follow-up care for existing patients, improving coordination and continuity of care. In Australia, outreach teams who initially feared being overwhelmed by the telephone support component found that their fears were not realized, as their remote colleagues tended to exhaust local options prior to contacting them.[29]

Based on the literature review, one unusual feature of the OPOP model is identified: Many of the OPOP outreach consultants are distantly based, with their home practice located in a different region (southern Ontario) than the one in which they provide outreach services. This contrasts with most of the models described in the literature, where outreach providers are typically based at the nearest referral-level facility. This raises the question of whether and how OPOP's unusual outreach geography influences its model, particularly with regards to the liaison and linkage functions of outreach, interactions with northern referral services, and coordination of care with northern-based psychiatrists.

2.   APPROACH

A mixed methods approach was used to elicit information on psychiatric outreach services. Quantitative and qualitative data were collected using a self-completed questionnaire and focus group discussions. The research protocols were reviewed and approved by the Research Ethics Boards at Laurentian

University, University of Toronto, University of Western Ontario, and University of Ottawa.

Study sample. "Consultants" are certified Psychiatrists who provide visiting specialist services in northern Ontario. The target sample for both the survey and the focus groups were the OPOP-affiliated consultants

providing outreach services in the North East and North West LHINs. They included consultants from the Northern Ontario Francophone Psychiatric Program (NOFPP), University of Ottawa; Northern Psychiatric Outreach Program at the Centre for Addiction and Mental Health (NPOP-C); and the University of Western Ontario-Extended Campus Program (UWO-ECP). A total of 34 outreach consultants were active in 2007-08.

Recruitment and participation. Consultants were initially contacted via email by their respective program administrators to inform them about the study and to request consent to be contacted for research purposes. A survey package was sent by CRaNHR to all consultants who consented. Questionnaires were completed between October 2008 and February 2009. Because some consultants provide outreach services to more than one community, respondents were requested to complete a separate questionnaire for up to two communities. A total of 27 usable questionnaires were received from 25 consultants. The estimated response rate from OPOP-affiliated consultants was 71%. Although the term "respondent" is used below, it bears repeating that two of the responses are for a second community. A small number (n<5) of consultants completed the survey who were not affiliated with OPOP programs but did provide outreach services in the north. Their responses were analyzed separately and their distinct contributions are noted throughout the analysis. Unless otherwise indicated, however, "consultant" refers to an OPOP-affiliated consultant.

At an OPOP-related meeting held in the Fall of 2008, participants were invited to participate in focus groups. Volunteers were divided into two groups, one for OPOP consultants providing Francophone services, and one for Anglophone services; the latter was a mixed group of OPOP consultants, OPOP administrators, and non-OPOP psychiatrists based in a northern urban referral centre (NURC).

Data collection, analysis, and synthesis. The survey questionnaire was divided into four parts: Outreach practice information and community characteristics; outreach practice characteristics; education; and consultant demographics. For many items, open-ended responses were permitted. A multi-mode survey was used to maximize response; survey participants could complete the survey in English or French, with a choice of

a web survey, a fillable electronic (MS Word) document, or a paper-based questionnaire. Data were compiled and analyzed using SPSS for descriptive statistics.

The question guide for the focus groups was designed to elicit discussion on the elements of "the OPOP Model," identify challenges experienced in the model's implementation, and identify possible areas for strengthening the program. Topics included the service delivery setting, challenges in the practice, collaboration, quality of care, and linkages to tertiary care services. Transcripts were analyzed thematically.

Confidentiality. To protect respondent confidentiality, place names have been replaced with generic place terms, such as COMMUNITY or NURC (northern urban referral centre) to disguise location. For the survey, the approved research ethics protocol requires the suppression of cell counts smaller than 5 to protect respondent confidentiality. Where aggregation of categories was not useful, but the category was considered important, the actual numbers were replaced with the phrases "small number" or "less than/fewer than 5." In graphs or tables, an asterisk (*) will be used to represent "less than five" or "less than 22 percent."

Interpretation. Because of the small numbers, a difference of 22 percentage points is used as a guideline for practical significance. The analysis emphases gross patterns, and readers are cautioned against attributing significance to small differences.

The goal of conducting both a quantitative and qualitative study was to increase the robustness of the findings through "triangulation" (the use of multiple data sources or data types to obtain a more comprehensive result). Data on themes common to both studies are presented in this report. For nearly all themes, the focus groups confirmed the findings of the survey, as well as provided explanatory details. Recommendations for enhancing the OPOP model are largely based on focus group data.

Limitations. Because of the small number of survey respondents and the degree of variation, the aggregate analysis should be viewed cautiously, as illustrative at the program level only, and not as representative of how or where individual consultants provide services. Francophone-serving consultants are overrepresented

among the OPOP-affiliated consultants in the focus groups. The focus group discussion did not include any psychiatrists based in the North West LHIN, thus their perspective is not represented. Finally, the non-OPOP sample is extremely small; although observed patterns are reported, these should be treated cautiously.

3.   RESULTS

3.1   Participant and Outreach Practice Characteristics

The majority (15/24) of survey respondents were affiliated with the Northern Psychiatric Outreach Program at the Centre for Addiction and Mental Health (NPOP-C), followed by six from the University of Ottawa-Northern Ontario Francophone Psychiatric Program (NOFPP), and three from the University of Western Ontario-Extended Campus Program (UWO-ECP). All of the non-OPOP respondents reported affiliation with the Northeast Mental Health Centre (NEMHC).

For most outreach communities (15/24), respondents reported that their outreach services were funded through the Visiting Specialist Clinics, MOHLTC Underserviced Areas Program (UAP). Six reported that their services were funded through the Urgent Locum program, MOHLTC/UAP. The respondents affiliated with the NEMHC reported NEMHC as the funding source.[i] The majority (19/24) indicated that they were <u>not</u> the sole psychiatric outreach consultant serving that particular community. Fewer than five of the outreach communities identified were one of the northern urban referral centres (NURCs) of North Bay, Sudbury, Sault Ste. Marie, Thunder Bay, or Timmins.

On average, OPOP-affiliated respondents had been providing outreach services for 10.3 years, with a range from 1-25 years. The mean length of service to a specific community was 9.75 years, suggesting that most consultants continued to work with the same community throughout their outreach career. Approximately one quarter of the OPOP consultants were considering retirement within the next five years.

Only half definitely intended to continue providing outreach services for the next five years.

Consultants were asked an open-ended question on their opinion regarding the most significant unmet needs in their outreach communities. The number of needs identified ranged from 1 to 6 per respondent, with a majority identifying one unmet need (Appendix D). The most frequently identified unmet need was lack of psychiatric consultants/services. However, non-psychiatric service needs were mentioned more often, including lack of psychotherapy, lack of primary care physicians, and lack of aboriginal health care. Two-thirds of respondents reported seeing patients without a referring primary care provider (16/24). On average, consultants reported that approximately 23% of their patients in their outreach practice lacked a primary care provider.

The median number of outreach trips per year was eight. However, there was considerable variation, ranging from two times per year to 48 times per year. January, July and August were the months with the fewest number of consultants traveling (10, 9, and 10 respectively), and September the month with the highest number of consultants traveling (17).

On average, consultants spent 2.8 days per trip in the community with a range of 0-14. The median and modal number of days was 2. On average, consultants saw 12 patients per visit, with responses ranging from 0-38 patients per visit. New patient consultations were on average 83 minutes long, ranging from 40-120 minutes. Follow-up visits took 49 minutes on average, with a range of 20-60.

Consultants were asked if their practice focused on a special population (multiple responses were permitted). Most consultants (65%) reported working with a general adult population, followed by 43% with an Aboriginal population, 35% with a francophone population, 30% with an elderly population, and 22% with children. A small number reported a focus on a prison population.

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[i] According to its most recent annual report (2007/2008), funding of the NEMHC community-based services comes from a funding envelope, Fund 2, Community Mental Health and Addictions, flowed through the NELHIN. Available 04/27/2009 at http://www.nemhc.on.ca/publications/library/Annual%20Report%202007_2008.pdf

3.2   Service Delivery Setting

On average, survey respondents reported seeing patients in two different service delivery settings, with consultants spending most of their time in hospitals and community mental health centres (CMHCs) (Figure 1). As might be expected, consultants whose services were funded through the Visiting Specialists Clinic program spent more time with patients at CMHCs, while those funded through the Urgent Locum program spent more time in hospitals.

Consultants spent approximately 20% of their time in a primary care setting, mainly in a community health centre or clinic. Fewer than 5 respondents indicated that they saw patients in an FP/GP/NP office. As some primary care services may be hospital-based, the relationship between setting and level of care is not always clear-cut. Other settings reported by a small number of participants included home visits, long-term care or nursing home facility, nursing station, and prison.

Figure 1: Service Delivery Settings

Percent of time seeing patients (n=23)
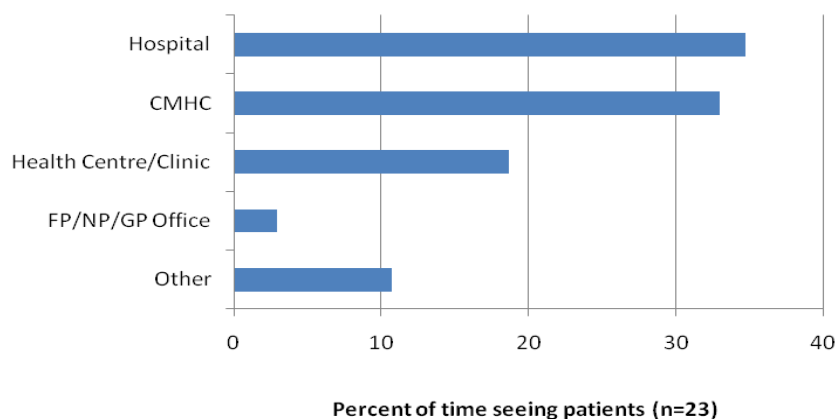
In the aggregate, these patterns mask a good deal of variation, however, with half of consultants (52%) reporting patient consultations in a single setting (the majority of these spending 100% of their time in a hospital). Focus group participants indicated that the setting could depend on the population served, or vice-versa:

> *... contrary to adult psych, for [geriatric psychiatry] the consultation location will vary a lot. This could be in a hospital setting, in a long term home, at home, in a clinic, etc. Therefore it's specialized [different] in that way.*

> *. . . if the psychiatrist goes to a community and his work is done in a hospital, the hospital has different needs than the community health centre. Because a hospital will first want that the doctor take care of the hospitalized psych patient.*

Results of the focus group discussions supported the survey findings. Most of the OPOP consultants discussed outreach to the secondary care level, usually a community-based mental health agency; only one consultant discussed direct interaction with family physicians.

> *...we recommend a community model, that is to say, we work with the local mental health team where the psychiatrist is visiting.*

> *...above all, my work is to support the onsite mental health team.*

> *It's been 20 years that I've been doing [outreach] at different service points, and the service has evolved in parallel with the environment. In the beginning I was alone, but now we have mental*

> *health teams . . . Therefore, a lot of my work is supporting these teams.*

The clinical setting was very different for non-OPOP consultants. In the survey, non-OPOP consultants reported spending more time providing home visits than OPOP consultants. In the aggregate, non-OPOP outreach consultants reported spending much less time in hospitals than their OPOP counterparts, only 7% vs. 35% of time. None of the non-OPOP consultants visited patients at CMHCs. In the focus groups, the non-OPOP "local" consultants described outreach models that included family physicians.

> *For the most part, I started out with the family doctors. I go to the clinics. And then we begin to connect with the community mental health and other resources there . . . And the other thing that I have done . . . is to develop Balint groups, so we meet once a month, basically. It's not just the family doctors, but anybody who has anything to do with mental health. . . And one of the other areas I've offered is the CBT [cognitive behavioural therapy] program over the lunch hour to teach them. Again, some of the family physicians and . . . some of the other community mental health workers from the site will be there.*

3.3 Elements of the Outreach Model

3.3.1 Direct and indirect care

Consultants were asked to estimate the proportion of clinical time they spent providing direct or indirect care, either in person or via telepsychiatry. For the survey, direct clinical care was defined as "Clinical care (e.g., consultation, assessment, diagnosis, therapy, treatment) involving direct patient interaction." This includes a face-to-face consultation with a patient alone, or with the patient and another provider. It also includes a telepsychiatry consultation using videoconferencing technology to interact directly with a patient." Indirect clinical care was defined as "Clinical care without direct patient interaction, e.g. consulting with a FP/GP or other

mental health worker about specific patients." On average, consultants reported spending 89% of their clinical care time in face-to-face direct clinical care. A small number reported spending time in in-person indirect care, and in direct care via telepsychiatry. None reported indirect care via telepsychiatry.

The survey question did not distinguish between different functions of these clinical consultations, e.g. assessment vs. treatment. Focus group participants reported a preference for a consultation function that left patient responsibility and management of treatment in the hands of community-based providers. However, community capacity was reported as a challenge. Where consultants could rely on local care teams, they were more likely to serve in a consulting capacity and could effectively oversee the treatment of a greater number of patients. But where the local providers could not provide the necessary care, the consultant had to provide direct care to fewer patients, spending more time during visits in follow-up consultations than new patient consultations.

> *. . . So more and more, it's that part of the job that I have to do. Where I become at times the primary therapist . . . It's too bad, but that's how it is. Because it means that at that time, I am less available to see numerous cases.*

> *It is a dilemma in communities that don't have family doctors.*

3.3.2 Onsite clinical elements

Nearly all the consultants reported outpatient consultations as part of their outreach practice; inpatient consultations were the next most common element (Figure 2). Nearly half reported collaborative care in a community mental health centre (48%). Nearly two-thirds reported provider consultations (although provider type was unspecified), and fewer than five consultants reported collaborative care in a primary care clinic. One-quarter reported making home visits.

Figure 2: Clinical elements of outreach

Percent of outreach practices
(n=23; *=<22 %)
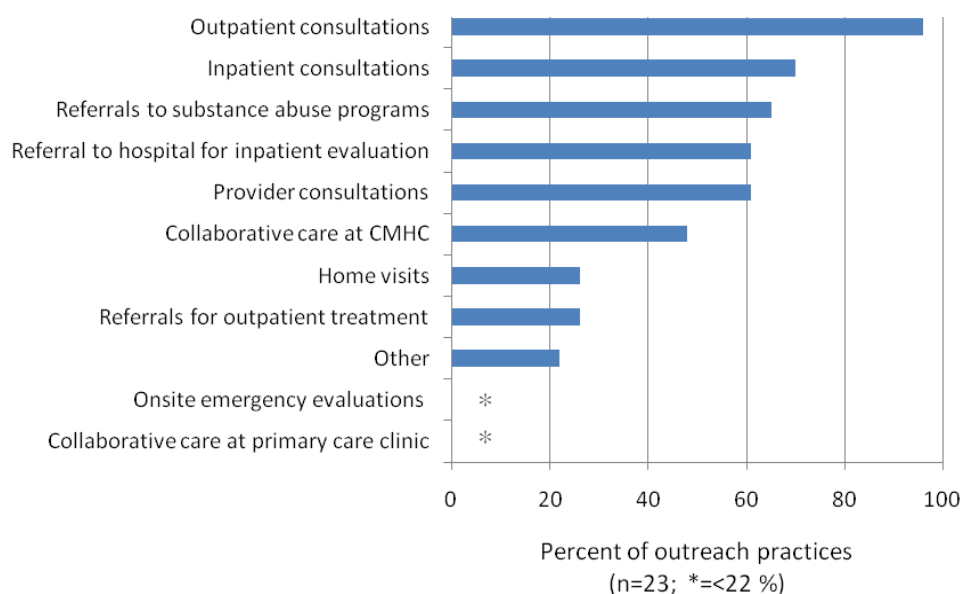
3.3.3 Between-visit support services

Consultants were asked if they had provided any between-visit support via telephone or email during the previous year, along with the reason for the support (Table 1). A majority (19/23) of OPOP consultants reported that they had. The most frequent contacts were with community mental health workers regarding patients that the consultant had previously seen (17/23), followed by contacts with primary care providers (PCPs) regarding patients that the consultant had previously seen (14/23).

Focus group participants described the need to make between-visit support services more systematic within the outreach model. However, the between-visit support was often quite specific to the unique needs of each community. One consultant described biweekly telephone meetings with two mental health teams in a community; another described regular contacts and between-visit follow-up as part of the outreach model; this consultant was also the only one to indicate using telepsychiatry to support the community, so this might be considered the "high end" of between-visit support services within OPOP:

. . . it's part of, it's not necessarily indicated in our remuneration modes, but there are telephone calls which are made regularly. I would assume an average of two times per month, without counting telepsychiatry, which I do every 2 ½-3 weeks after the visit. And one week before returning. So that there isn't too much . . . And so, telephone calls, re-prescription for pharmacists, and telepsych interventions, recommendations, modification to prescriptions between visits...

| **Table 1. Provision of between-visit support during the previous year (n=23)**	
	(%)
Any telephone or email support provided during the previous year	83
What was the nature of this support?	
CMHW – patient previously seen	74
PCP – patient previously seen	61
PCP – patient in crisis	52
PCP – medication management	43
Prescription renewal	43
PCP – patient not previously seen	35
PCP – additional information	30
PCP – systems navigation	*
Other – 3rd party information needs	*
Multiple responses possible. * < 5.	

3.4   Patterns of Interaction

3.4.1   Consultation arrangements. Respondents were asked to estimate the percentage of their consultations in a variety of consultation arrangements, including consulting with the patient alone; with the primary care provider (PCP) alone; with the patient and PCP together; with a mental health team; and with the patient and a non-medical provider together. Primary care providers were defined on the questionnaire as family physicians, general practice physicians, and nurse practitioners. This question aimed at understanding the level of collaboration based on patterns of interaction with other providers in the outreach community. This was challenging to assess on a survey, as the literature suggests that the answer is often "it depends," however, the goal was to try to understand the "typical" patterns of interaction for consultants.

In the aggregate, nearly two-thirds of consultations were with a patient alone; about 17% of consultations were jointly conducted with the primary care provider and patient, and 12% were with a mental health team (Figure 3). Less than 5% of consultations were with the patient and a non-medical provider, or with a primary care provider alone. (Non-medical professionals were identified as case worker, case manager, counsellor, and First Nations mental health counsellor/interpreter).

Figure 3: Consultation arrangements
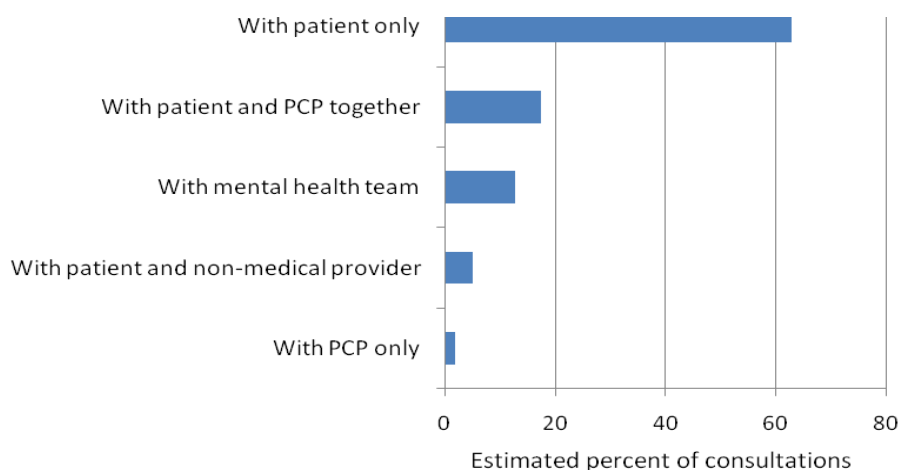
However, the aggregate results presented in the above bar graph mask a good deal of variation. A small number reported 100% of their consultations with patients alone. However, one out of four consultants reported more than half of their consultations to include other providers. Nearly half of the respondents (46%) reported joint consultation with patients and primary care providers, but most of these reported less than 50% of their consultations in this configuration. Only 6 consultants reported consultations with the PCP alone, all reporting 10% or fewer of their consultations in this configuration.

Another question asked "How often did you provide clinical services in the following arrangements?" using a Likert-type item: Ten categories (including "Other") were listed, with response options of frequently, sometimes, rarely and never, and no answer. Here again, face-to-face with the patient alone was the most frequently reported pattern, followed by together with case/social workers and together with CMHC staff. For "face to face with the patient and primary care provider", the modal category was "never" (10 respondents).

Focus group participants were in agreement that OPOP consultants tended to work in teams, but they highlighted the difficulty of defining teamwork. For example, it could be difficult to draw distinctions between practice models or "levels" of collaboration, because they could vary situationally or by patient. Individual or parallel practice could co-exist within team-based models of practice:

...yes, once again it depends on the case. It's definitely a team, I think ideally it's a team, but once again, what is the team? There's a lot of areas where a team is superfluous.

... this is why I am saying that it's sometimes a team and other times it's one person. Sometimes it's two people. Therefore, that's my answer, it's both. But it's always within the framework of a team. I think that that's essential because no one goes into the north to see a patient and do individual psychotherapy when there's not a team in place.

Level of interest, particularly among family physicians, could be a determinant of the model in terms of shared care or collaboration. Local providers were not always perceived as being interested in teaming up with psychiatrists. Service delivery setting and experience with collaboration could also affect primary care providers' interest in, and ability to collaborate as well, particularly when the outreach site was not co-located with these other providers. One OPOP consultant described a typical "referral" model, in which he was provided an office at the local hospital, and the family practice physicians referred patients. The consultant treated the patients separately, but this model was not his preference.

And I think one of the determinants of the model has to do with the family physicians and the other health practitioners and their skills -- willingness, ability to collaborate, you know? There have been some clinics, communities where I have gone and they really just want to send you the patients and be done with them, there are some physicians in communities who want to do that. And then there are others who are really happy to be involved and want the patient back and want the continuity going. (Non-OPOP Consultant)

I consult [directly with patients] and then send them back if they don't need me anymore. Other than that, I follow up with them a few times and then bring them back to their family physicians. That's the model that seems to work I think and that's what the family physicians would like to do. Some other people might be

saying "but I don't want to do this, I want to do team work. My team can do the work." And I want to be, I want to be doing the [team care]. But the family physicians just don't want to.

This level of interest in collaborating with the visiting psychiatrist was seen to have parallels in whether the local providers practiced in an interdisciplinary team or not; one participant observed that this was often a function of providers' age/generation and training. Payment models also influenced willingness to collaborate, for example, among family health team models.

Well, one of the remote communities that I go to has a new family health team, and it's a fairly big one. And so there are a number of family physicians over a fairly large geographical area, which makes it harder to collaborate. And most of them have been there for 20 years doing it a particular way and so they really don't have a lot of experience at collaborating . . . So they're really having trouble with the idea of "how do we actually do this?" Both from a physical [geographical] perspective and then . . . the culture of collaboration is new to them . . . (Non-OPOP Consultant)

They may want to collaborate, but they say "Well we don't have social workers. We don't have the ability to pay psychiatrists. We don't have the administrative support staff." They're primarily fee-for-service, or else they're rostered in a limited way, so, they're kind of frustrated then. So I think that would make a difference in what kind of collaboration you would do. . . Because, if you have a [salaried] Family Health Team, they're going to be paid to do the collaborative work. If you're fee-for-service, the family doctor is not going to be paid to collaborate. (Non-OPOP Consultant)

However, enthusiasm for team work among outreach consultants was also tempered by the reality of local capacity constraints. One consultant described experiencing the failure of community-based teams to provide the needed care for patients, and consciously retreated from overreliance on local teams to mixing models of direct care and consultation. Another

described the challenge of working with a team while maintaining personal standards and accepting medical responsibility for the patient:

> *...So I realized, once again, that it's case-based, which is centred on the patient . . . Certainly the team, when the team can support the patient, it's all the better. But when there's an aspect that is very specific that the team cannot support, especially when there are very few doctors on site . . . there's still a treatment part, for better or worse. So more and more, it's that part of the job that I have to do. Where I become at times the primary therapist, who is also borrowed by the team.*

> *And I believe that we must be responsible. It's very very difficult. It's easy and superficial to function as a team and to delegate and all, but there's still the notion of medical responsibility.*

3.4.2 Sharing patient information. Consultants were asked about how they typically shared patient information with referring primary care providers; multiple responses were permitted (Figure 4). The most common modes reported by a majority of consultants were a written letter or summary (88%), telephone call (67%), and patient chart (54%). Informal face-to-face conversations were reported by 38% of consultants. Fewer than five consultants reported formal face-to-face modes, including formal conversations; provider presence during the consultation, or case review.

Figure 4:

Typical mode of sharing patient information with referring primary care provider

Percent of OPOP consultants
(n=23; * < 20 %)
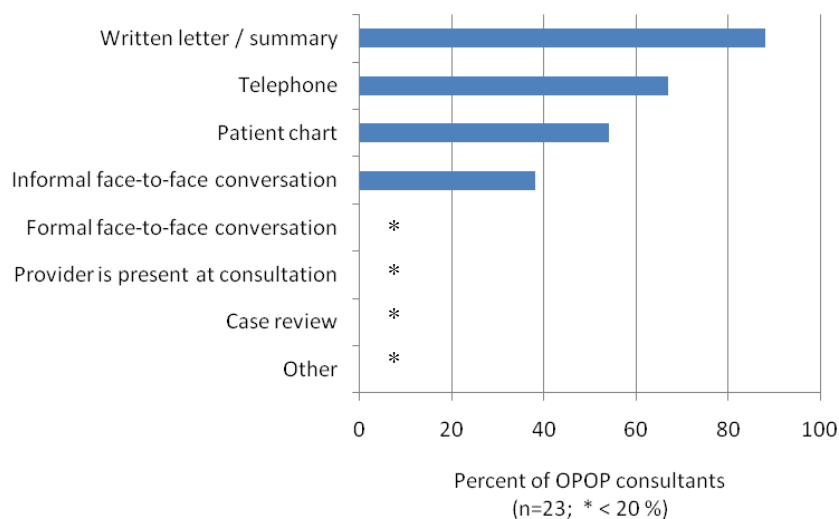
The focus group participants also indicated reliance on written communication and patient files, however these were not without problems. One consultant described how a previous consultant had refused to share patient files with other physicians at the hospital, and created some resentment towards psychiatrists. The new consultant worked very hard to establish a collaborative relationship with other staff, by ensuring access to patient files. Some commented on the "separateness" of psychiatric files, and the special confidentiality of the psychiatric file.

> *...but everyone that I see, there's always a report sent to the family doctor. .. But the family doctor doesn't have the professional notes. But he will have all the reports that I write up as the consultant.*

> *The psychiatric file is really in parallel, there's a special confidentiality attached to the psychiatric file, that is to say ... consultation reports are often sent to the family doctor and then get thrown into the general file but it's not*

automatic. So every external clinic, for example, has its own files, which they don't share with the others.

3.5   Educational activities

One of the main objectives of outreach to underserviced areas is to increase the capacity of local providers to provide appropriate assessment, care, and referrals. Education has long been a component of OPOP programs, but little is known about how much and what type of education is performed by consultants. Interestingly, the topic of education prompted a number of lengthy, open-ended responses.

The survey considered a variety of educational modalities, including informal education and formal education (in-person as part of regular visit; in person outside of regular visit; and distance education). The survey also explored barriers to increasing the role of education and possible solutions.

Formal and informal education.   Consultants were asked to estimate the proportion of educational activities that was formal vs. informal. On average, consultants reported spending two-thirds of their educational time on informal activities (65%), compared with formal education (31%). Forty percent reported no time spent on formal education, in contrast with a small percentage who reported no time in informal education. And, 40% of consultants reported 100% of their educational activity as informal, compared with a small percent who reported 100% of their educational activity as formal.

Focus group participants described how informal education is woven into various consultation processes:

Also, they'll present to me around a table, because I will give my impressions and suggestions. So it's really at the team level . . . I find all this helps promote a form of education within the group. So we have 'round table' discussions and what we say to one person we find ourselves to 4 or 5 or 6 people at the same time. So all at once, everyone's on the same page…

… but I try to use the process of active follow-up consultation, conjoint with the family doctor, and finally be able to say at the end, yes, we are totally finished. We've obtained all our objectives. And I use this a lot as teaching for the team and for the family doctor . . . I wanted to add that that's the process - using the consultation model as a process of teaching also.

On-site formal education. Survey results indicated that in about 35% of OPOP outreach practices, consultants have conducted formal educational activities for mental health professionals, and with residents or medical students doing a rotation or elective in the north. In 27% of outreach practices, consultants had conducted educational activities with primary care providers. A small number of practices had included education to other psychiatrists, and hospital rounds.   A small number reported receiving requests that they were unable to fulfill; requests were for conducting rounds, and for taking on residents or medical students in their outreach practice.

Despite interest on the part of consultants, some found it challenging in small communities to attract a "critical mass" of interested learners to educational sessions. One open-ended comment described the frustration:

I have been asked by local family physicians, and gave talks in the past, but very few attend (e.g. one per lecture), so I stopped doing it. I had arrangements to talk to non-physician workers recently (and have done this in the past), but the arrangements fell through, and I have not rebooked. I would like to arrange an informal rounds to discuss cases of patients family doctors are seeing, however I am still looking for a time to do this that will be attended by at least a couple of local physicians.

Still, others managed to make education a significant part of outreach activities:

Vast array of topics; do two days of pure formal teaching per year, and lots of informal, a major part of the enterprise.

Consultants were asked whether if they purposively scheduled or set aside time for educational activities on their trips. This question was asked in an open-ended format to allow respondents the opportunity to describe their approach in their own words. Of the 16 who responded to this item, seven provided a negative response; a small number of these indicated that they had in the past but don't do it anymore. For example:

> *No, my trips are done on the weekends, and educational activities are not wanted on weekends.*

> *I used to, but the referral lists get so long that I don't have time to do them anymore and instead provide education via videoconferencing when I am in my non-outreach practice.*

Among the nine who provided a positive response, seven set aside time for formal education, at least on some visits; fewer than five set aside time for informal education.

Distance education. Consultants were also asked if distance education was part of their outreach practice. Only a small number of consultants responded affirmatively, for education to local mental health professionals, and education for residents or medical students doing a core rotation or elective in the north. None reported conducting distance education to psychiatrists, primary care practitioners, or conducting rounds to the north via distance education.

Topics of education. Consultants were also asked about the source of topics for formal educational sessions. Local mental health professionals were the most frequently reported source, with half of consultants indicating this group. The consultants themselves were the second most common source (38%), followed by primary care providers and case/social workers. The subject most frequently reported was case management for a particular disorder or problem (56%), followed by medication management (31%). A small number reported legal competence, forensics, and "many" as topics of education.

Barriers to formal education. Consultants were asked to indicate the single most significant barrier to increasing educational activities in their outreach

practice. Multiple responses were not permitted for this item, which frustrated some respondents and resulted in "Other" being the most frequently selected barrier (38%), followed by "too much clinical work" (24%). Among the "other" responses, the majority of comments indicated that they could not identify "the most significant barrier" because there were multiple significant barriers (e.g. "all of the above"). Respondents offered a number of open-ended responses to this item, however; one common idea expressed was the lack of interested family practice/primary care providers, or lack of interest expressed by the community:

> *Lack of family physician in place, the locums are not interested in this.*

> *Lack of time e.g. FPs .*

> *It's a combination of a lack of local interest, as well as no specific funding. The events usually occur before or after the clinical day, and it's tough to get motivated to prepare a novel topic that is poorly attended, without any specific compensation.*

Participants were then asked to identify what they would want or need to increase the amount of time spent on educational activities in their outreach practice; this time, multiple responses were permitted (Table 2). More interest from the local community and providers was selected by 65% of respondents, and prioritized as most important need for consultants.

Table 2: Support needed to increase the proportion of time spent on educational activities (n=23).	
	%
More interest from the local community, providers	65
Availability of appropriate curricula/education materials	30
Increase in total amount of time spent in community	26
More administrative support	26
Payment for education services / financial support	22
More clinical support	*
Nothing – I can't/don't want to spend more time on education	*
Multiple responses permitted. * < 5.	

3.6   Linkages with Tertiary Care Centres

3.6.1   Distance to psychiatric inpatient services. Respondents were asked to indicate the nearest facility to their outreach location with psychiatric in patient services (Schedule 1 designated facilities).   With the exception of those serving communities with a psychiatric inpatient facility (8), the distance to the nearest facility was at least 100 kilometers for the majority of outreach communities; the next nearest facility was more than 200 kilometers (Table 3). Thus, when consultants made referrals to inpatient services, it involved significant travel distances for patients.   Two facilities outside of northern Ontario were identified as the 2nd nearest facility. In an open-ended response, one consultant indicated the need to consider more than geographic distance, stating that access to the nearest designated facility was "*more in theory than in practice*."

Table 3. Distance to the nearest two facilities with psychiatric inpatient services (n=22)		
	Nearest (n)	Next Nearest (n)
In the same community/facility	8	*
Less than 100 km	*	*
Between 100 km-200 km	8	*
More than 200 km	6	16
Don't know / no answer	*	*

* < 5

3.6.2   Referrals for inpatient services.   Consultants were asked if they had ever referred patients for inpatient services as part of their outreach practice, and to where. A majority (59%) had made referrals to the nearest inpatient facility. An equal percentage made referrals to the next-nearest facility and to a facility in southern Ontario (41%).   About one-third (32%) indicated referral to another facility in northern Ontario.

Focus group participants discussed the issue of referrals, and that although the goal of OPOP is to provide care within the community, there was sometimes need to refer specialized cases out of the community. However, opinions varied greatly on this issue. In one case, the "home" hospital of a consultant reserved beds for "northern" patients of the consultant. This was seen as

a benefit of the OPOP program, to provide tertiary services to northern residents that might not be available at closer (northern) hospitals.

> *So I think that is an advantage of OPOP. To have the possibility of tertiary care, to bring your patient back with you to your community and to offer him the whole gamut of services that exist in Toronto or in Ottawa or in London, and which don't necessarily exist in [NURC-3], or don't exist here [NURC-1].*

However, this experience was not universal.   Not all consultants were affiliated with a hospital in their home community, nor were all hospitals interested in this linkage.

> *When I started at a community hospital in CITY, and they found out that I was doing consultations to the North, the chief of medicine told me, "I will accept you here, as long as you promise me that you won't bring patients from the north here. . . [Now] I do private practice, so I have a lot of trouble having access to services from CITY. Trying to find a bed for someone who isn't from the CITY area is not easy.*

One consultant felt that the "community approach" was to utilize resources from within the community, regardless of the limitations of those resources.

> *The community approach is that we utilize resources which are obviously from the community. And if the environment is [NURC-3], it will be [NURC-3]. If the environment is [NURC-2], it will be [NURC-2]. Often the resource is the hospital with whom we're working. So it's like that. Or, it's crisis intervention. So it's very, very rare that we will use tertiary services from afar.*

> *I have never referred anyone outside of [NURC-2] or [NURC-1].*

Several commented that rather than referring patients to services outside the region, a strategy was needed to link providers, including specialists in the north, with subspecialists in higher-level facilities in the south.

... what I would like internally is to network, to really connect the north and the south. And that there is this type of responsibility where it would be natural for the urban centres to share the abundance. I don't know which model, but still, we should have this type of networking.

3.6.3 Impacts of OPOP on northern psychiatric services.

Focus group participants were asked to comment on the impacts of OPOP services in the north. Discussions indicated that OPOP increased access to psychiatry in the north, both through delivery of services and through support to northern-based psychiatrists. In addition to reducing the need for patients to travel to the south, positive impacts of psychiatric outreach included shorter waiting lists in OPOP-served communities for psychiatry than in the larger cities; more efficient service delivery; and increasing the professional credibility of non-medical mental health workers among the community-based providers.

So before [OPOP], we would pay the plane ticket for the patient, his wife, or his father, and we would send them to Toronto for consultation and then they would go back. So definitely this was a major element to justify the outreach program . . . it is more efficient than it was before.

I think the thing is the support for the [local] teams, so the credibility of these professionals who are competent . . . I find that it's still a medical world. And so at least there are psychiatrists that can work with the onsite/local teams. And as far as I'm concerned, it makes for a [mental health] centre which is credible to other professionals.

In the other group, NURC-based psychiatrists and OPOP administrators alike recognized the importance of the Extended Campus Program (ECP) to the development of northern-based psychiatric services. The availability of faculty positions for NURC psychiatrists through the ECP for more than 20 years was seen as an important factor in the region's ability to recruit and retain psychiatrists and develop their own district-wide services. NURC-based psychiatrists were of the opinion that there were now a sufficient number of psychiatrists in the NURC so that the district outreach program effectively covered

the hospital district. However, the resources were only sufficient to cover the NURC's own hospital district. They agreed that if OPOP were not providing services to other northern districts, they would not be able to fill the gap in outreach services. Moreover, demand on local services would greatly increase.

If there were no OPOP, we would be inundated.

NURC-based psychiatrists were asked if they interacted with OPOP psychiatric outreach consultants. NURC psychiatrists reported that they were unlikely to know whether a referred patient had been previously seen by an OPOP outreach consultant, as they were more likely to receive a referral from and communicate with a FP/GP.

... we don't get that much information from that source. The family physician is the one on call at the time. He's stuck and he wants the patient to be transferred, so he'll be transferred . . . And lack of communication with the OPOP consultant... I'm not faulting the OPOP consultants, by any means, they are there, you know, once a month, or once in two months... So it's hard to predict when the patient is getting discharged as to exactly when the patient will get seen.

The organization of tertiary psychiatric services within northern Ontario was viewed as somewhat problematic, which could affect efforts to establish effective linkages with northern referral centres. Psychiatrists based in one NURC reported frustration with regional referral services in another NURC, tending to refer to southern Ontario when needed.

...[the] other parts of tertiary care, what you are referring to is specialist assessment. [NURC-2] [provides] specialty care, but . . . if I really need specialist assessment, I get quicker service in London, Hamilton, and Toronto, not in [NURC-2].

3.7 Recommendations for Enhancing the OPOP Model

Focus group participants made a number of recommendations that included: developing a tool to aid in prioritizing patients; strengthening between-visit support services; increasing the use of education as a

capacity building tool; developing multidisciplinary outreach; and, creating a subspeciality support service for northern psychiatrists.

Develop a tool for prioritizing patients. One challenge discussed at length was how to determine the best use of the outreach consultant's time within the community. Part of "accommodating the community" was accepting the patients that community providers referred to the visiting consultant. Still, this challenged the program in terms of matching "need" with availability of consultants; in some cases, consultants felt that referrals were not always appropriate, or at least not the best use of the consultant's limited time.

> *...I think that standardization at the level of urgency of who should be seen, that I think would help a lot. Because, effectively, it's very arbitrary . . . So if there's something that I would like from the program [OPOP], I would really like it if we could supply the centres . . . a type of checklist, something that's pre-evaluation, where we could normalize, or prioritize the demands.*

There were several dilemmas involved in prioritizing. Certain types of clients may routinely require more time than others. And, while generally agreeing that those with the most severe pathologies should be seen first, there was also a great need for treatment among those with less severe conditions. The inclusion of "easy patients," those who could be treated with a minimal amount of follow-up, could positively affect professional satisfaction and team morale. And, from a prevention and quality-of-life perspective, treating less severe patients could have impacts that were not always obvious when focusing exclusively on pathology. The group agreed that this was an important matter for further research, because to their knowledge, no such tool existed.

Strengthen between-visit support services. A key concern for visiting consultants was the care and follow up of the patient after the visiting consultant leaves. This issue of follow-up care between visits prompted a number of recommendations or suggestions for improvement to the OPOP model.

> *... there are also elements, and I think we will start talking about it, that we need to add. . . between each visit there are interactions that must take place – and that's where telepsychiatry comes into consideration. Or another mechanism of communication must exist, because the simple presence of the psychiatrist with these 3 days per month visits is not enough. . . A local follow-up would facilitate the staff's ability to interact with the psychiatrist between visits, to discuss with him say, if your treatment worked or did not work.*

Strengthen the education component. A vocal minority discussed the need for the OPOP model to go beyond the delivery of clinical care, to increasing local capacity:

> *And can I just add one thing? I think an education/training component is important as well. So that there is something in addition left in the community. So that it shouldn't perhaps all be patient-focused. It should have an education, training focus.*

One unprompted comment indicated the value of asking about education:

> *This survey helped me realize all the teaching I don't do (as compared with my regular work-place).*

Consider multidisciplinary outreach. When consultants were asked to consider enhancements to the OPOP model, discussion turned towards the idea of a team-based outreach model, and which disciplines should be on a multidisciplinary outreach team. Psychologists were the most frequently mentioned team member; others included nurse practitioners, psychiatric nurses, social workers, occupational therapists, Aboriginal specialists. Participants mentioned psychological testing and cognitive behavioural therapy (CBT) as needed services that would enhance the OPOP model and make their work as psychiatric specialists more effective. Another benefit of team-based outreach would be more time for the psychiatrist to devote to education.

> *And I also think that this model would be a multi-disciplinary model . . . could we get a*

psychologist? That is also something we want. A social worker is less rare.

But yes, which would be very useful, is a psychologist, who is a clinician. And what I'm missing the most is someone who, ideally, would be someone who could also do psychological testing, that would be miraculous.

Create a psychiatric subspecialty support service. Consultants also discussed the idea of developing a non-traveling specialist resource to support the visiting specialists, particularly to create access to psychiatric sub-specialities for psychiatrists practicing in the north:

But if we could have a roster of people that we could ask consultations from and who are part of our group without necessarily having this person come with us. I think that we have to be realistic

but say right now we have no one in the community who we can ask. It makes no dang sense to ask someone to go to CITY to visit this type of service but if we could have someone that we could ask [from OPOP] for a psychological consultation with, for certain cases. And if we had communication, whether by telepsychiatry or what have you, it would be extraordinary if we had that type of resource.

I wonder if it would be useful to have tertiary care centres that are, develop a relationship with some place like NURC-1 for instance. So if a NURC-1 psychiatrist needs help, they can call, they might get a telepsychiatry consultation. It may just be to call and talk on the telephone. I think lots of times, it's not just family doctors who need help with collaboration, it's northern psychiatrists who need help as well.

4.   SUMMARY AND CONCLUSIONS

What is the 'OPOP model' of psychiatric outreach? Given the degree of variation in responses and reported patterns, it is difficult to generalize about a single model. Moreover, consultants indicate mixed patterns within a given outreach practice. Focus group participants indicated that there was no single "model," but rather multiple models that fit the varied needs and capacities of northern communities, as well as individual consultant preferences and constraints. Community providers are strong influences on the form and functions of the outreach model. Individual outreach practices evolved over time and were affected in part by historical differences among program partners, mental health reform, and the development of community mental health services. Although there were some cases where consultants had successfully enacted change to improve their "model", consultants generally viewed their model as responsive to community needs and interests; most tried to accommodate the preferences of the community.

For a majority of consultants, the main model appears to be a parallel model of outreach to the secondary level (hospitals and community mental health centres), rather than to the primary care level. This model was multifaceted, similar to a consultation-liaison model of

outreach to the primary care level, however, the psychiatrist had limited direct interaction with primary care providers, and most of the intervention elements involved community mental health workers and teams rather than primary care providers and teams. In most communities, the community mental health providers were responsible for care coordination and service integration with family physicians and other care providers.

Although most outreach consultants provide some treatment, most appear to leave the ongoing care and management of the patient in the hands of community-based providers; this appears necessary because most consultants travel to their outreach communities less than once a month. However, most consultants provided between-visit support by telephone or email, primarily to community mental health workers but also to family physicians. Although most consultants have conducted some education activities, a minority provide formal education services. Twice as much informal education occurs as does formal education. Consultant recommendations to enhance the model included more systematic between-visit support to outreach communities and more attention to education and capacity-building activities.

Most consultants reported high levels of collaboration and teamwork with community mental health providers. However, few reported team-based practice elements such as joint consultations or case conferences. Because the research design was grounded in the literature review, and the literature focused on outreach to primary care rather than outreach to community mental health services, the survey may have not fully captured these practices at the secondary level.

About one out of five OPOP consultants provided regular outreach services to the primary care level, more often to a community health centre setting than to a family practice. For others, face-to-face interactions with FP/GPs appeared relatively rare; the main modes of communication with family physicians were written and telephone communication. Service sites were rarely co-located with family practice clinics, limiting opportunities for informal contact. Because family physicians in rural and remote communities also provide emergency department and primary care coverage within hospitals, consultants working in hospitals could interact with family physicians outside of the usual "primary care" setting described in the literature; such interactions do not produce the community-based integration of mental health and primary care envisioned by shared care models.

Some consultants expressed a desire to work more collaboratively with FP/GPs, but reported a number of barriers to this collaboration. Barriers included a shortage of FP/GPs and community reliance on locums; payment mechanisms for family physicians that discouraged collaborative activities; and a lack of time and interest among some primary care physicians.

Other outreach models were also reported by consultants. These included consultant-liaison and shared care models with primary care; an itinerant model of outreach to multiple communities; and the Assertive Community Treatment (ACT) model. These models were more common among consultants whose program or home base was closer to the outreach communities (e.g. consultants based in a northern urban referral centre, or NURC), and whose proximity enabled the more frequent visits and higher levels of interaction and support that would be indicated by those models.

There were some differences in the findings from the survey and the focus groups on the amount of direct clinical care. On the survey, most consultants appeared to be working in a traditional "visiting specialist" model, providing direct clinical care in a parallel or referral arrangement. In the focus groups, OPOP consultants emphasized their consultative function, rather than treatment. This difference may be due to the difference in the participant samples, or to the greater nuance and explanatory detail afforded to the focus group participants. In the focus groups, it became clear that "direct care" did not necessarily include primary responsibility for ongoing treatment of the patient, which would be the key difference between a treatment and a consultation model. Focus group participants indicated a preference for an indirect consultation model over direct care treatment model, although both were needed to meet the needs of their patients. From the consultants' perspective, the main drawback of an indirect care model (consultation model) was the variable capacity of local providers to provide the needed care, particularly in communities where there were shortages of family physicians.

Linkages. In the focus groups, only the northern-based psychiatrists and one of the other OPOP consultants indicated a linkage between their outreach practice and home-based practice, as an indicator of the linkage function between community-based and referral level services. Consultants based in a NURC and providing outreach services within their service area were more likely to interact with family physicians, and more likely to report the liaison functions. These findings support the notion that the outreach geography (distance from home practice to outreach practice) is an important factor in the model. A key benefit of the OPOP model was consultants' relative anonymity in the community, which appeared to reassure patients of confidentiality and increase the acceptability of psychiatric referrals.

Impacts on northern psychiatric services. Focus group participants recognized a number of positive impacts of the OPOP outreach beyond increasing community-based access to psychiatry in northern Ontario. NURC-based psychiatrists in particular commented on how the Extended Campus Program improved recruitment and retention of psychiatrists in the NURC, and capacity was now sufficient to cover the district with their own outreach services. However, local capacity would be

overwhelmed without OPOP outreach services to other northern districts.

Recommendations for enhancement. From the consultants' perspective, a benefit of strengthening linkages between outreach providers and regional services would be improved support to visiting psychiatrists in the field, for enhanced range and quality of outreach services. Possibilities were discussed for model expansion centred on the improvement of multidisciplinary support, such as the development of multidisciplinary outreach teams (psychologists, psychiatric nurses, and nurse practitioners were the most desired disciplines for an outreach team), and/or development of an on-call resource of various disciplines including subspecialists in psychiatry. Northern-based psychiatrists also desired this resource.

Conclusions. The finding that most consultants performed outreach services at the secondary level was surprising because models described in the literature focused almost exclusively on outreach to the primary health care sector; there were few cases of this model identified in the literature. This study will contribute to the scarce literature on models of psychiatric outreach to the community mental health sector.

One intriguing discrepancy was between consultants' perception of their outreach practices as being team-based and collaborative, yet a minority reported key elements associated with team-based collaborative practice, such as joint consultations. This discrepancy could be explained by a number of possibilities, including problems with the questionnaire; multiple and disparate understandings of "collaborative care", "team-based care", and "shared care"; and static models of collaboration that fail to adequately account for the dynamism and adaptive nature of collaborative practice.

Another possibility is that urban-based models of collaboration do not fit the rural and remote context, given, for example, reduced access to family physicians and other community-based providers with whom to collaborate. A number of related questions emerge: How would consultants explain these discrepancies? Is "collaboration" different in rural and remote practice than in urban practice? Do existing models of collaboration need to be revised to fit the rural and remote context, and if so, how? Given the policy focus on collaboration and shared care, it is important to "rural proof" these models.

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APPENDIX A: List of Acronyms

CAMH	Centre for Addiction and Mental Health
CBT	Cognitive Behavioural Therapy
CHC	Community Health Centre
CMHC	Community Mental Health Centre
CMHW	Community Mental Health Worker
CRaNHR	Centre for Rural and Northern Health Research
ECP	Extended Campus Program
FP	Family Practice Physician
FRCPC	Fellow of the Royal College of Physicians and Surgeons of Canada
GP	General Practice Physician
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
NOMEC	Northeastern Medical Education Corporation
NOSM	Northern Ontario School of Medicine
NURC	Northern Urban Referral Centre (North Bay, Sault Ste. Marie, Sudbury, Thunder Bay, Timmins)
NP	Nurse Practitioner
NPOP-C	Northern Psychiatric Outreach Program at the Centre for Addiction and Mental Health (formerly UTPOP)
OPOP	Ontario Psychiatric Outreach Program
PCP	Primary Care Provider (family physician, general practitioner, nurse practitioner)
PHC	Primary Health Care
UAP	Underserviced Areas Program
UTPOP	University of Toronto Psychiatric Outreach Program (now NPOP-C)
UWO	University of Western Ontario

APPENDIX B: Definitions used in the Survey

Formal education   In the context of medical education, "formal education" refers to planned activities designed to instruct or inform groups of learners. These activities include seminars, workshops, continuing medical education and other information sessions offered to local community medical/health professionals and other interested parties.

Informal education   In the context of medical education, "informal education" refers to spontaneous and situation-driven instruction that may occur during ad-hoc or casual conversations between a specialist/educator and another physician, health care worker, or allied health professional. The "learner" may be an individual or small group. Informal education can take place in corridors, hallways, cafeterias, staff lounges, telephone calls, etc., and typically involves high levels of interaction between teacher and learner.

Distance education   A mode of instructional delivery whereby educational activities are conducted via distance-based Information and Communication Technologies (ICT), for example, videoconferencing.

Direct clinical care   Clinical care (e.g., consultation, assessment, diagnosis, therapy, treatment) involving direct patient interaction. This includes a face-to-face consultation with a patient alone, or with the patient and another provider. It also includes a telepsychiatry consultation using videoconferencing technology to interact directly with a patient.

Indirect clinical care   Clinical care without direct patient interaction, e.g. consulting with a FP/GP or other mental health worker about specific patients. Indirect care may be provided in-person or via telepsychiatry.

Primary care provider   Family Physician (FP) or General Practitioner (GP). In some contexts including Northern Ontario, a Nurse Practitioner (NP) may also serve as a primary care provider.

Outreach community   "Community" has many meanings. For this survey, we are asking about the geographic entity ("place") to which you travel regularly as a visiting specialist (do not include one-time or non-recurring locum services).   This may be the place name of a single place, but may also represent two or more adjacent places from which the majority of patients are drawn.   Most consultants provide visiting specialist services to a single outreach community, but, some have two outreach communities.

Telephone or email support services   A consultant's use of telephone, email or other distance-based communication technology to provide indirect and/or non-clinical assistance to a healthcare provider in your outreach community; does not include face-to-face or direct clinical services.

APPENDIX C: Map of Northern Ontario Communities Served by OPOP-affiliated Psychiatric Outreach Consultants (General Adult Psychiatry).
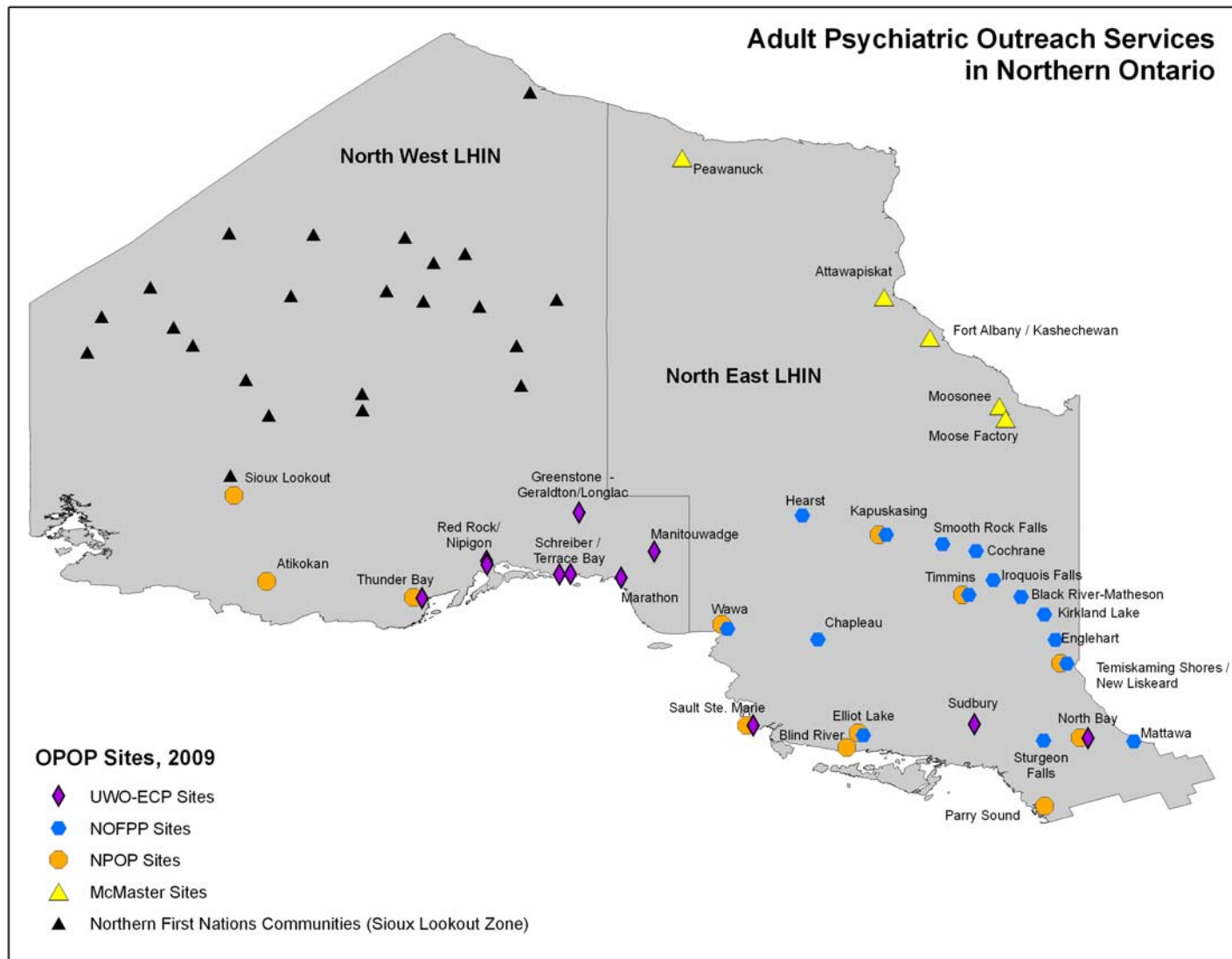
Spatial data sources: Boundary Files: Statistics Canada, *Health Regions, Ontario, LHINs,* 2006, freely distributed for non-commercial uses at http://www.statcan.gc.ca.[30] Feature data: Based on the Natural Resources Canada *Atlas of Canada 1,000,000 National Frameworks Data, Canadian Place Names*, v6, 2009 (modified), freely distributed through geogratis.gc.ca.[31] Results or views expressed are those of the authors and are not those of Statistics Canada or Natural Resources Canada. Map produced using ESRI ArcMap 9.3 (2008). Environmental Systems Resource Institute (ESRI), Redlands, CA, USA.

APPENDIX D: Most significant unmet needs related to mental health care in outreach communities

Unmet needs for non-psychiatric providers & services (n=15)

psychotherapy

primary care physicians

aboriginal health care

school-based mental health educational supports

continuity of care

trauma treatment

substance abuse treatment

services for developmentally delayed

front line staff

Unmet needs for psychiatric providers & services (n=13)

psychiatric consultants/services

speciality psychiatry or referrals for subspecialties

timely access

 inpatient/outpatient services

Other related service needs (n=9)

socioeconomic development (poverty; unemployment; inadequate housing;
        lack of community development resources)

quality of care (evidence-based treatment; alternatives to pharmacotherapy)

prescription drug addiction

transient populations (aboriginal)

stigma of mental illness

Note: Within each category, responses are listed in order of frequency.