Enhancing Collaboration through Shared Care in Peterborough
Family Health Teams and Mental Health Services
S Nadkarni, P Wilkins, J Whitehead, B Cameron, D Harterre, G McNestry
Peterborough

- City population:
- County population:
- Schedule 1 Facility with 28 inpatient psychiatric beds, AOP, and 3 Separate Vote programs serving four counties
- Currently 5 family health teams developed in 2006 with 75 doctors

Historical Perspective

- Shared care between Psychiatry and Family Practice has been discussed in the literature since the 1990’s with models evolving since then.
- Shared care models have been recommended to improve diagnosis and management of mental health (Can Fam Physician 2008:54:884-9)
Historical Perspective

• In the mid 1990’s a program was developed at PRHC in response to severe shortage of psychiatrists and difficulty providing adequate mental health care.

Mid 1990s

• Gradual depletion of Psychiatric manpower through the early 1990’s
• 10-12 Family Physicians recruited to support on call and care of inpatients
• Psychiatrist acted as mentor / consultant to group
• Education Program was provided

Later 1990s

• Psychiatric manpower began to grow slowly
• 5 Family physicians remained as part of the Dept of Psychiatry
• 1 FP worked out of Adult Outpatient Program
• 3 FPs continued to provide on call coverage
2000’s

- Psychiatric manpower continued to grow at PRHC during the time the FHT model was developed and implemented
- 1 FP continues to provide on call support to this day
- 2 FP work out of the Adult Outpatient Program

Community Need

- 15-50% of all patients in family medicine have significant psychological dysfunction
- 21% receive care from mental health specialists
- 54% are seen by primary care (Regier et al.)
- Limited mental health resources in the community

2006 and beyond

- Family Health Team Formulated in 2006
Collaborative Goals Set

- Managers & FP from Adult Outpatient Program, Family Health Team Lead Physician and Exec. Director met with Dr. Nick Kates and colleagues in Hamilton
- Proposal for a Mental Health Project forwarded along with overall FHT proposal to the Ministry

### Family Health Teams

<table>
<thead>
<tr>
<th>Family Health Team</th>
<th>Physicians</th>
<th>Admin Staff</th>
<th>Front Desk</th>
<th>Social Worker</th>
<th>Dietitian</th>
<th>Pharmacist</th>
<th>Nurse</th>
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<tbody>
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<td>Greater Peterborough Medical Centre</td>
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<td>2</td>
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<tr>
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<td>Partners in Pregnancy Clinic (PIPC)</td>
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</tbody>
</table>

### FP Patient Rosters

- Family physicians see approximately 20% more patients than those rostered to them.
Mental Health Project in FHT’s

- Mental Health Liaison role developed to lead the project
- 12 FTE Mental Health Clinicians of various disciplines
- Addressing the mental health needs for those with mild to moderate illness

Primary Care Focus with Mental Illness

Psychiatrist Active Case Load

[Bar chart showing case loads for different psychiatrists]
Current Phase

- Assignment of psychiatrists to individual FHTs
- Approx. 8 hours per month of psychiatry to each FHT
- Meetings between individual FHT and Mental Health Services to establish working relationships specific to needs of FHT

Current Phase

- Identification of unassigned patients within MHS for assignment to FHT FP in a shared care relationship
- Identification of outcome indicators and process for data collection
- Development of processes to enhance access to range of MHS such as ED Crisis Services and AOP groups
Lessons Learned

• Family physicians spend considerable time diagnosing and treating psychiatric problems (Orden 2009).
• Shared Care can be brought about through removal of systemic barriers (Craven 2006)
  – Poor communication
  – Insufficient access to psychiatrists
  – Lack of continuity of care
  – Encouragement of collaborative practice

Lessons Learned

• Our Enhanced Collaborative Model
  – Interdisciplinary
  – Offers complimentary services and mutual support
  – Ensures timely appropriate services from providers in suitable location
Future Opportunities

• Evaluation of the Shared Model
• Creation of Communities of Practice or “Webs of Care” enabled by telemedicine
• Availability as a Regional / Provincial Resource
• Expansion of model within Long term care, Community Health Centres, other FHTs

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