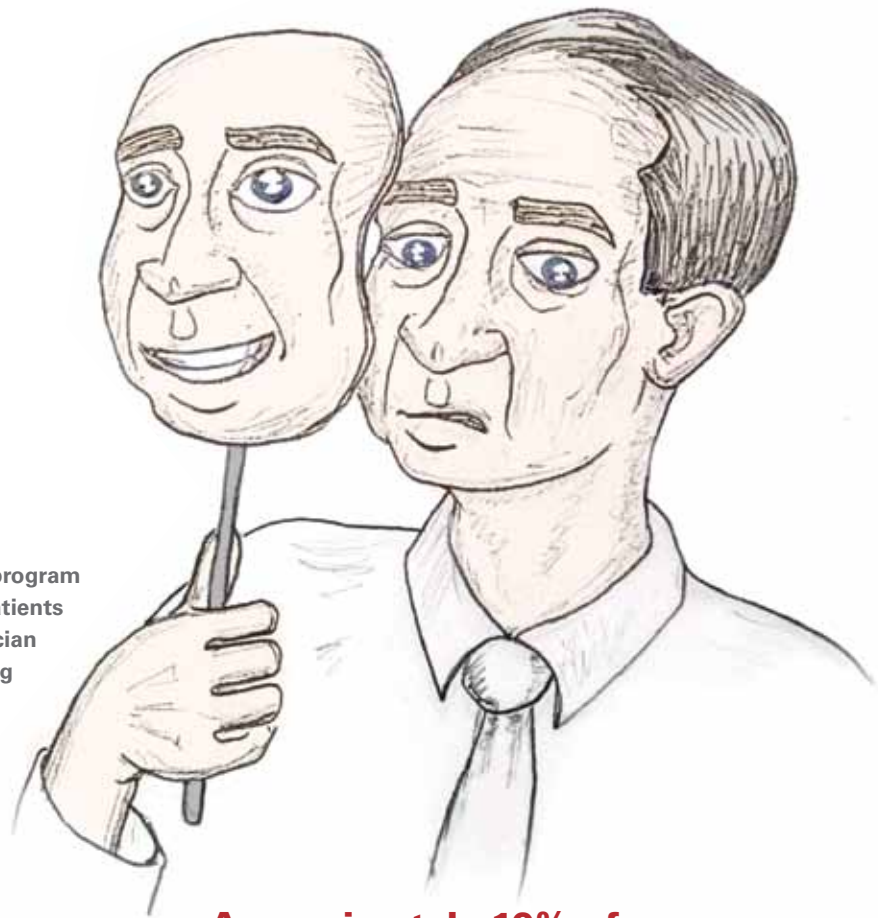


Improving Mental Healthcare

by Primary Care Physicians in British Columbia

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Abstract

This article describes a new and innovative training program to assist family physicians to better care for their patients with mental health conditions. Trained family physician leaders train other family physicians. The training package includes a wide range of tools that can be used by physicians in their own offices. Preliminary results indicate that physicians want to be trained, and data indicate a high degree of success for the training module. Some 91% of physicians who attended the training indicated that it had improved their practice, and 94% indicated that it had improved patient care. The training materials are online for those who wish to learn more.

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Mental health conditions are common in Canada, yet they remain difficult to diagnose and treat in the primary care setting. It is also difficult to obtain accurate and up-to-date data on the prevalence of mental illness. However, current estimates indicate that approximately 10% of Canadians experience a mental illness in a given year, and one in five may have a mental illness in their lifetime (Canadian Mental Health Association 2005; Mood Disorders Society of Canada 2009). In 2006, the Senate Committee on Social Affairs, Science and Technology released its report on mental health in Canada. This report resulted in

the establishment of the Mental Health Commission of Canada in 2007 (Mental Health Commission 2010). In 2009, the commission released a framework for a Mental Health Strategy in Canada (Mental Health Commission of Canada 2009). This article presents information on a new and innovative learning module developed in British Columbia that trains family physicians to better care for their patients with mental health symptoms. The learning module is consistent with the seven goals enunciated in the Mental Health Strategy.

The mental health learning module arose out of larger comprehensive efforts to reform and revitalize primary care and improve patient care in the province. In 2003, seeking solutions to a declining interest among general practitioners (GPs) to practise family medicine, the BC government created the General Practice Services Committee (GPSC), a joint committee of doctors and members of government (Cavers et al. 2010). Over the past seven years, the GPSC has introduced a number of initiatives including clinical incentive payments, maternity care bonuses, recruitment incentives for new family physicians, and training modules to support enhanced clinical and administrative skills.

In 2007, the GPSC created the Practice Support Program (PSP) to support family physicians in operationalizing training initiatives for clinical redesign, practice-management redesign and continuing education/professional development in high-priority areas. The first four training modules were for advanced access, chronic disease management, patient self-management and group visits (MacCarthy et al. 2009).

In 2008, a survey of GPs found that mental health diagnosis, treatment and care planning were rated as the highest-priority need for further education, training and support. Starting in 2003, the first four authors of this article (R.W., H.C., M.M. and J.S.) developed a manual that provides an organized approach for GPs to assist their patients with mental health issues, from diagnosis through to treatment, with cognitive behavioural interpersonal skills centred on patient engagement. Further discussions with colleagues led to the incorporation of two additional cognitive behavioural skill approaches into an overall training module. In addition, a skills development component for medical office assistants (MOAs) was included. This module was adopted by the GPSC as its fifth PSP learning module.

Ninety-four percent of GPs felt the training had resulted in improved patient care.

The aims of the mental health learning module were to increase GP skills and confidence in the diagnosis and treatment of mental health conditions using evidence-based strategies and tools; increase physicians' awareness of community mental health resources; increase physicians' ability to develop care plans; improve family physician collaboration with psychiatrists and mental health clinicians in the community; improve the patient experience; and promote the engagement of patients in the management of their mental health conditions, within the constraints of a primary care practice and the fee code structure. For the MOAs, the aims were to help them to develop booking practices, interpersonal skills with patients who have mental

disorders, and billing procedures for new fee codes related to mental health.

GP champions were identified to be trained in this module and then teach it to their colleagues. The program was pilot tested in the summer and fall of 2009. Following the quality improvement model of Plan-Do-Study-Act (Langley et al. 2009), two training sessions were separated by a seven-week action period in which tools were practised and modified. Mental health clinicians and psychiatrists from each of the five health authorities were also included in the training. Depression was used as the lens for this training. (Details on the mental health learning module can be accessed at <http://www.gpsc.bc.ca/psp-learning/mental-health/tools-resources>, which contains all the tools and videos for the training/implementation of the module, including the hyperlinked algorithm that contains all module components.)

Practice support coordinators were hired from each of the province's five health authorities to facilitate the recruitment and training of GPs. These coordinators provided support and helped the GPs and MOAs in their region to operationalize the module. The training program was then gradually rolled out province-wide.

By August 31, 2010, 981 of the province's 3,300 community GPs had enrolled. Attendees participate in three paid learning sessions that are separated by two paid action periods in which GPs and MOAs practice the components of the module. After each action period, participants attend the next learning session to share their experiences and their concerns/problems, learn the next components and decide on any modifications they might make.

Screening tools such as the Patient Health Questionnaire for Depression (PHQ-9) help GPs select the appropriate patients. The GPs can then use one, or all, of the three approaches taught:

1. **Cognitive behavioural interpersonal skills.** Using the Cognitive Behavioural Interpersonal Skills Manual, the GP is trained to do a diagnostic assessment interview (DAI) and to develop a problem list and resource (strengths) list with the patient; these are then organized into a problem list action (care) plan (PLAP) that directs treatment strategies. These treatment strategies are cognitive behavioural interpersonal skills in the form of one-page handouts from the manual, organized according to activation, relaxation and cognition and lifestyle skills. The assessment components (DAI and PLAP) are designed to be done within 20 minutes each. The skills are designed to be done in 10-minute sessions.
2. **Antidepressant Skills Workbook.** GPs are trained to coach patients in the use of an Antidepressant Skills Workbook developed by the Canadian Centre for Applied Research in Mental Health and Addiction.
3. **Bounce Back.** GPs learn about the community Bounce

Back program delivered by the Canadian Mental Health Association. The GP provides the patient with the Bounce Back video and makes a referral for community telephone coaching. The coaching is provided by a lay coach supervised by a psychologist.

In addition, a Family Physician Guide developed by the BC Ministry of Health Services and the Canadian Centre for Applied Research in Mental Health and Addiction provides a more in-depth resource for the GPs and is linked to the mental health learning module through a medication algorithm.

While it is too soon to evaluate patient outcomes per se, early evaluation of the GP and MOA participants shows positive responses to the training module. Based on surveys completed at the end of the third and final learning session by participating GPs ($n = 136$, a response rate of 60.2%) and MOAs ($n = 71$, a response rate of 39.7%) to March 31, 2010, the initial evaluation found that GPs agreed, or strongly agreed, on the following:

- What they had learned had improved their practice (91.0%).
- The training had resulted in improved patient care (94.0%).
- They had learned something new that they were incorporating into their practice (98.5%).
- Attendance at the learning module had increased their job satisfaction (78.5%).
- The training had enhanced their skills to conduct a DAI (91.9%).
- The training had enhanced their skills in treating mental health conditions (90.4%).
- The training had enabled them to decrease their reliance on prescribing antidepressant medication (41.5%).
- The care they could provide after having attended the learning module increased their patients' ability to return to work (61.9%).

MOAs agreed, or strongly agreed on the following:

- Their working relationships with their GPs improved (76.8%).
- They felt comfortable in dealing with mental health patients (80.5%).
- Participation in the learning module was a positive experience (91.0%).

The experiences of the physicians who participated in the mental health learning module show that family physicians are willing recipients of training. The impact on the patient population of this training program is still to be determined, and this will be the focus of further evaluation of the mental health module. **HQ**

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