

# Mental Health Practice and Attitudes of Family Physicians Can Be Changed!

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## Abstract

**Objectives:** An adult mental health module was developed in British Columbia to increase the use of evidence-based screening and cognitive behavioral self-management tools as well as medications that fit within busy family physician time constraints and payment systems. Aims were to enhance family physician skills, comfort, and confidence in diagnosing and treating mental health patients using the lens of depression; to improve patient experience and partnership; to increase use of action or care plans; and to increase mental health literacy and comfort of medical office assistants.

**Methods:** The British Columbia Practice Support Program delivered the module using the Plan-Do-Study-Act cycle for learning improvement. Family physicians were trained in adult mental health, and medical office assistants were trained in mental health first aid. Following initial testing, the adult mental health module was implemented across the province.

**Results:** More than 1400 of the province's 3300 full-service family physicians have completed or started training. Family physicians reported high to very high success implementing self-management tools into their practices and the overall positive impact this approach had on patients. These measures were sustained or improved at 3 to 6 months after completion of the module. An Opening Minds Survey for health care professionals showed a decrease in stigmatizing attitudes of family physicians.

**Conclusions:** The adult mental health module is changing the way participants practice. Office-based primary mental health care can be improved through reimbursed training and support for physicians to implement practical, time-efficient tools that conform to payment schemes. The module provided behavior-changing tools that seem to be changing stigmatizing attitudes towards this patient population. This unexpected discovery has piqued the interest of stigma experts at the Mental Health Commission of Canada.

## Introduction

Most patients with mental health conditions see their family physician first.<sup>1</sup> There are not enough mental health specialists to see all the patients who need to be seen.<sup>2</sup> The availability of mental health specialists varies across regions. Mental health issues are often intertwined with physical health issues (eg, chronic conditions). A certain percentage of the population could

benefit from psychiatric or specialized treatment, but many do not need specialized care, making primary care a logical place for their management in many cases. Through a joint British Columbia Medical Association/Ministry of Health committee survey, family physicians in British Columbia identified more training in mental health care as their top priority need. In the literature, family physicians generally identify the availability of educational opportunities in mental health care as an area that needs improvement.<sup>3</sup> In addition, there seems to be widespread agreement that an improvement in the recognition of mental illnesses by family physicians is required.<sup>4</sup>

A team from a local urgent mental health clinic observed that the diagnoses of substance abuse, bipolar disorder, obsessive-compulsive disorder, and posttraumatic stress disorder were frequently missed in family physician referrals. In addition, medication seemed to be the predominant approach contrary to what the evidence-base and guidelines would recommend.<sup>5</sup> Finally, it appeared that family physicians did not seem to fully engage their patients as partners in care. In response, the team developed the Cognitive Behavioral Interpersonal Skills (CBIS) manual, a protocol tool using depression as a lens because of its high prevalence, to help family physicians better assess and treat their patients' conditions. This manual consists of a diagnostic screening interview tool and information about self-management cognitive behavioral interpersonal skills, encouraging physicians to use skills, not only pills. The CBIS manual came to the attention of the British Columbia Medical Association/Ministry collaborative committee responsible for primary care renewal, called the General Practice Services Committee, at the same time as the survey had identified mental health care as the top priority.

Working toward the Institute for Health Care Improvement's Triple Aim approach<sup>6</sup> (improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care), the General Practices Service Committee then funded a provincial quality-improvement (QI) effort through its Practice Support Program (PSP) that used this tool as its core.<sup>7</sup> Together with two other self-management cognitive behavioral tools (the Bounce Back Program, a community-based mental health coaching program from the British Columbia Division of the Canadian Mental Health Association, and the Antidepressant Skills Workbook [ASW]), these tools formed the basis of the PSP adult mental health module. This module is a collection of

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**... family physicians reported increased personal job satisfaction and a decreased reliance on prescribing antidepressant medications ...**

mental health resources for physicians to improve their comfort and confidence in the diagnosis and treatment of mental health patients through approaches such as engaging patients as partners and self-management, all within busy family practice time constraints and fitting with their fee-for-service payment codes.<sup>8,9</sup>

The PSP adult mental health module was thus aimed at enabling family physicians to provide the best primary care possible for patients with depression and anxiety as a primary diagnosis, comorbid with chronic diseases such as diabetes or heart disease, or comorbid with other mental health disorders, before needing to refer the patient into the specialist system. Although Bounce Back is meant to be used in the care of people with mild and moderate depression and anxiety, and the ASW is intended for people with mild and moderate depression, CBIS skills have also been used to treat the comorbid depression and anxiety of chronic stable, serious, and persistent mental disorders.

**Method**

The PSP consists of a trained team that provides a provincewide vehicle that can support the training and office implementation of specific QI training modules in their geographic areas. There are five such teams in British Columbia, one for each of the Regional Health Authorities across the province. Learning modules are developed by experts from across Canada and British Columbia, and are facilitated by senior staff at the British Columbia Medical Association, including a senior physician experienced in bringing about transformational change and a staff member with a Masters degree and experience in program and policy development and QI. Regional Support Team members working in the Regional Health Authorities come from a variety of backgrounds. Many have clinical training and most also have training in QI. Experienced physicians called “peer facilitators” teach the learning modules.

In the case of the adult mental health module, peer facilitators from each Regional Health Authority were first trained in the module. In addition, medical office assistants were provided with training in mental health first aid<sup>10</sup> to improve their mental health literacy and comfort with mental health patients.

Once the facilitators had been trained and had redesigned their own office practices accordingly, attention was then turned to the recruitment and training of the family physicians in their region. The PSP used the Plan-Do-Study-Act Cycle for learning and improvement.<sup>11</sup> Peer-led learning sessions were also attended by a local psychiatrist and a nonphysician mental health clinician who acted as expert resources and support as needed. As noted in Figure 1, the adult mental health module consists of three peer-led learning sessions, which are interspersed with two action periods during which physicians implement the new learnings in their day-to-day medical practice.

Although the order of training varied among health authorities depending on geographic area and perceived physician receptivity, Figure 1 presents one order of training. In this example, in the first half-day session, the family physicians were given an overview of the module, and an overview of the CBIS manual with its assessment components, skills flow charts, and handouts. Then, drilling down, the assessment pieces consisting of the 9-item depression scale of the Patient Health Questionnaire (PHQ-9), Diagnostic Assessment Interviews, and problem and

resource list handouts were demonstrated live or with videos, followed by role-playing of those components. Training was then given on how to access Bounce Back’s telephone coaching program. The physicians and the support team then planned their action periods and identified how many PHQ-9s, Diagnostic Assessment Interviews and problem and resource lists they would practice as deliverables, the short tests evaluating change and their measurement, and how family physicians would be supported on-site. During the action periods, which often lasted about seven weeks, they practiced as planned with the on-site support of the PSP support team.

When the team regrouped for the second half-day of training, they shared their learnings, challenges, opportunities, and solutions; made their modifications; and proceeded to be trained in taking the problem list and converting it into the action plan. Here, after a live or video demonstration, they role-played the physician and patient together looking at each problem on a problem list, without the goal of fixing the problem but rather with the goal of managing the problem. Patient engagement in taking part in their own solutions to their own problems was encouraged. Role players, in both physician and patient roles, identified where relaxation, activation, cognitions, and lifestyle skills could best help, as well as medications and whether other referrals were required. This created an action/care plan. Select CBIS skills were chosen to demonstrate live or by video, and once again the physicians role-played working with the patient on chosen skills. They were then trained in the Antidepressant Skills Workbook (ASW), another self-management tool, which helped literate patients who could work on their own at home and return to be coached by their physicians. Demonstrations were live or by video and role-play followed. Again family physicians planned their action period and went away and practiced developing the care plan, the CBIS skills, and the skills from the ASW for the next seven weeks or so.

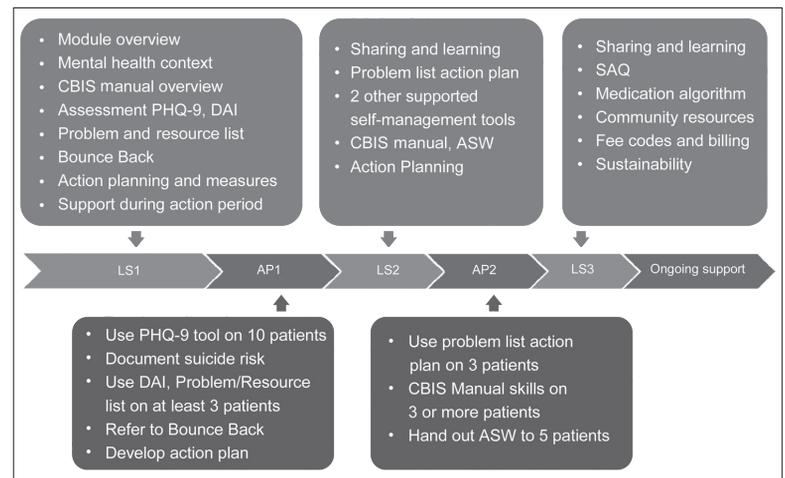


Figure 1. Overview of the adult mental health learning module.

AP = action period; ASW = Antidepressant Skills Workbook; CBIS = Cognitive Behavioral Interpersonal Skills; DAI = Diagnostic Assessment interview; LS = learning session; PHQ-9 = 9-item depression scale of the Patient Health Questionnaire; SAQ = self-assessment questionnaire.

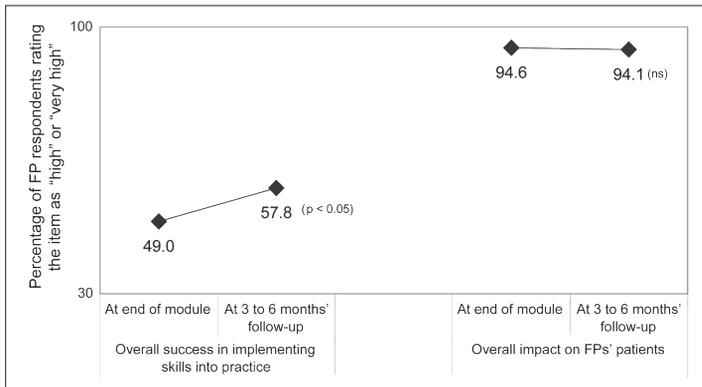


Figure 2. Family physicians' ratings of the overall success and impact of the adult mental health module.

FP = family physician; ns = not significant.

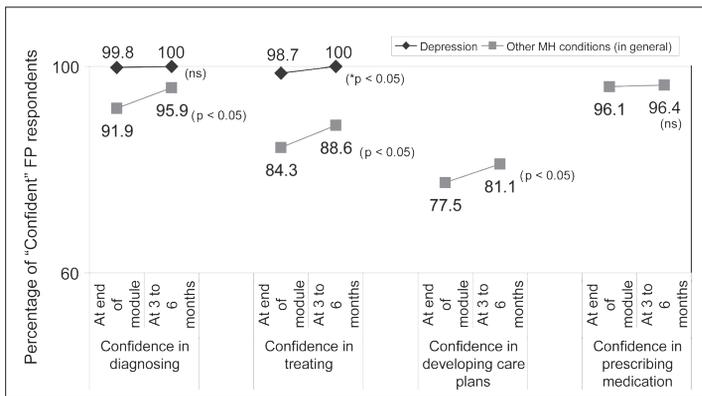


Figure 3. Family physicians' confidence in providing mental health care at module completion and three to six months after training.

FP = family physician; MH = mental health; ns = not significant.

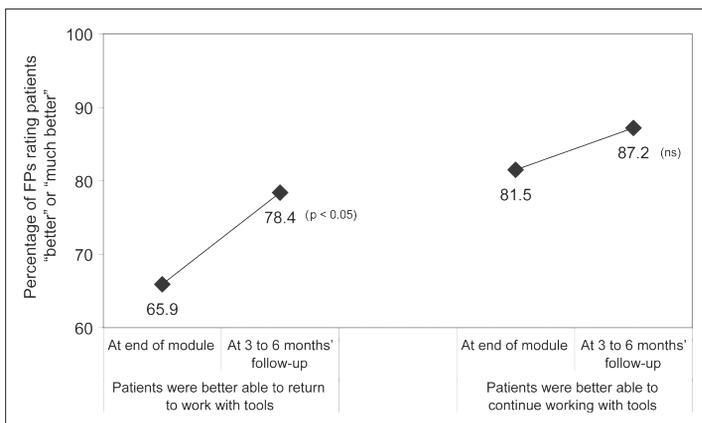


Figure 4. Perceived improvement in patient work life after training.

FP = family physician; ns = not significant.

In the final half-day learning session, they regrouped and again shared their learnings, challenges, opportunities, and solutions. They were finally trained in the CBIS self-assessment questionnaire, which identified reaction styles such as perfectionist, pleasing, or overthinking in the patient with accompanying self-management skills that could help the patient manage. Training continued with a medication usage piece, sharing community resource information, and training in how best to use the fee codes to bill for this work; then the teams planned for sustainability. Physicians were reimbursed for their time and for implementing the mental health tools. The PSP team was available to help support the physicians and medical office assistants in the implementation of the tools and the office redesign required.<sup>12</sup> The training usually took about five months to cover the three learning sessions and the two action periods that separated the learning sessions.

Participants were surveyed at the end of training and at 3 to 6 months after training. The number of trained physicians continues to increase. The evaluation of the adult mental health module was composed of comprehensive, validated surveys. The surveys were completed by family physicians and medical office assistants at the end of the last learning session of the adult mental health module, and a 3- to 6-month follow-up survey was completed by family physicians. This article focuses on the findings for family physicians. However, the results were also positive for the 293 medical office assistants who completed their end-of-module surveys. Overall, 92.4% of medical office assistants indicated that participating in the adult mental health module had been a positive experience. Finally, as this project was an evaluation of a QI initiative it did not, according to Canadian standards, require an ethics review.

An invitation was received to do a 1-day training in the CBIS and ASW components of the module at the National Family Medicine Forum in Oct 2011. The Mental Health Commission of Canada's Opening Minds Anti Stigma Committee, partnering with the Canadian Medical Association and the Mood Disorders Society of Canada, had used CBIS in their online anti-stigma course<sup>13</sup> and expressed an interest in seeing whether the CBIS and ASW could decrease any stigmatizing attitudes of the family physicians taking the 1-day training at the Family Medicine Forum. They surveyed the family physicians and residents taking this training immediately before and immediately after the training. A 20-item questionnaire, the Opening Minds Survey for Health Care Providers (OMS-HC), was the instrument used to assess attitudes toward people with mental illness. The OMS-HC requires participants to respond to statements using a 5-point Likert scale from "strongly agree" to "strongly disagree." The OMS-HC was developed and validated in an earlier study.<sup>14</sup> The process of scale development included testing and refinement of an item-pool, obtaining feedback from experts and focus groups, and psychometric evaluation. Psychometric analyses indicated that the OMS-HC scale could be scored using a single total score, but that it encompasses 5 stigma domains: social distance, disclosure, self-stigma, prejudice, and devaluation—and the social responsibility and role of health practitioners. The overall scores provide a global index of stigmatization. Since its development, the scale has been used in more than 15 studies evaluating anti-stigma interventions and has demonstrated both internal consistency and sensitivity to change (unpublished data [SP]).<sup>15</sup>

## Results

In British Columbia, more than 1400 of the province's 3300 full-service family physicians had started training by November 2012. Of the family physicians who returned to the training, 592 completed end-of-training evaluation surveys before the end of March 2012 (a response rate of 63.1%).

At the end of the training, family physicians reported high to very high success in implementing the self-management tools into their practice and the overall positive to very positive impact they believed this approach had had on patients (Figure 2). Family physicians reported an increased confidence in diagnosing and treating their mental health patients, in developing care plans, and in prescribing medications (Figure 3). The physicians reported that they believed that their patients were better able to stay at work or return to work (Figure 4). Measures were sustained or improved at 3 to 6 months (Figures 2 to 4). Additional findings showed that family physicians reported increased personal job satisfaction (67.2%) and a decreased reliance on prescribing antidepressant medications (39.5%).<sup>16</sup>

The antistigma survey showed a decrease of 10% in the stigmatizing attitude of the family physicians and residents attending the Montreal Family Medicine Forum 2012. This change compared favorably to changes of about 5% generally seen in studies with the OMS-HC of various health professional groups using contact-based antistigma approaches (unpublished data [SP]).

## Discussion

The impact of any intervention on population health is determined partially by its efficacy but also by its reach within the population. One of the greatest strengths of the PSP approach, mediated partially by its train-the-trainer implementation strategy, has been a capacity for implementation in a large number of primary care practices, resulting in coverage for a large proportion of the population.

The Mental Health Commission of Canada result of a 10% decrease in stigmatizing attitudes was the largest decrease in any of its surveys done in various areas (unpublished data [SP]). It also seems that by increasing family physician confidence and comfort by giving them a useful approach and good tools, they are more welcoming to their mental health patients and less stigmatizing. This has led to a novel hypothesis. Up until now, most antistigma initiatives have focused on changing attitudes and hoping that these attitudes will lead to changes in behavior. The novel hypothesis derived from the adult mental health PSP program is that decreasing anxiety by providing tools leads to behavior change that only then leads to changed attitudes. This hypothesis aligns with Cognitive Behavioral Theory, which states that it is easier to change behavior than to change feelings, and that behavior change changes feelings. This is leading to new research directions in the stigma field.

## Conclusions

Family physicians enjoy the PSP approach. The evidence shows that the changes implemented were sustained or improved. Thus we conclude that this adult mental health module is

changing the way family physicians work with their mental health patients across the province, and is changing their practices. This is a provincewide practice redesign. It allows the primary care physician to provide the best primary care possible, before needing to refer to the specialist system. ♦

## Disclosure Statement

*The author(s) have no conflicts of interest to disclose.*

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