Teaching Behavioral Sciences to Family Practice Residents: The “Shared Care” Approach

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Conflict of Interest
Jon Davine

Lundbeck, Canada.
Educational Presentation, Advisory Board Member
AGENDA

- Description of Behavioural Sciences Program at McMaster University
- Description of program at University of Manitoba
- Using video in clinical supervision
Overview

- Introduction
- Description of Behavioural Sciences Program (DFM, McMaster University)
- Goals of Program
- Teaching Methods
- Evaluation
- Conclusions
Introduction

- 70% of antidepressants and 90% of anxiolytics are prescribed by Family MD’s.
Introduction

- 15 – 50% of all patients in family medicine have significant psychological dysfunction
- 21% receive care from mental health specialists
- 54% receive care from primary care only
- “De Facto Mental Health System”
Introduction

- 1,000 people

- 250 → 230 → 140 → 17 → 6

  Psychologic Morbidity
  Based on GHQ
  Go to FD
  Identified by FD
  Involved with MH specialist
  in patient psych treatment

Based on GHQ specialist treatment
Description of Program

- Hybrid model at McMaster (FP SW Psychiatrist triad)
- No Block Rotation
- ½ day behavioral sciences x 2 years
- 3 ‘units’ in Hamilton (40-50 residents per year)
- 3 ‘satellite units’ (20 residents)
- PGY1’s and PGY2’s are separated
Description of Program

- Teaching techniques
  - Small group format
  - Case presentations – video, oral
  - Process issues – communication, interpersonal skills
  - Content issues – diagnostics, treatments, life cycle, problem based
Description of Program

➢ Other Teaching Techniques

➢ Topic centred
➢ 20-30 topics / 2 years
➢ Arise out of cases presented, flexible
➢ Some didactic presentations
➢ Large group sessions – resident driven, invited speakers
Description of Program

- Other Teaching Techniques
  - Case presentations
  - Role playing
  - Visits to community centres (detox, shelters)
  - Representatives from community present to the unit (SISO, CAS)
Description of Program

Other Teaching Techniques

- Tutor shows his/her own tape
- Viewed by the group
- Tutor as model
- Process and content issues explored
Description of Program

- **Who?**
  - Psychiatrist, Family Doctor, Social Worker
  - Hybrid Model
  - Multi-disciplinary Model
  - Different viewpoints
Description of Program

➢ Where?

➢ Family Practice Clinic
Description of Program

- Central coordinator, site coordinators (MFP, SFHC, community, KW, Niagara, Brampton)
- Four times per year
- All tutors attend from all units
- Evaluate program. Discuss what has worked and what has not worked.
- Share ideas/resources.
- Team building/faculty development.
Description of Program

Psychotherapy Modalities

1. Supportive
2. CBT (change therapy)
3. Solution Focused therapy
4. Motivational interviewing
Description of Program

- Curriculum Requirements
- BS is a clinical rotation!
- Attendance Guidelines
- Participation Guidelines
- Evaluation Guidelines
Goals of Program

- Enhance collaborative, interprofessional skills.
- Enhance communication, interpersonal skills.
- Promote FP as primary delivery of mental health care, psych as consultant.
Goals of Program

- Increase detection, diagnostic and treatment skills
- Psychopharmacology
- Psychotherapeutics
Other Teaching Methods

- Large Group Sessions
- 4x/year
- PGY1’s and PGY2’s are separated
- Topics such as counseling, ethical issues, etc.
- Residents organize some of these sessions themselves
Other Teaching Methods

New update – PeTR
Enrichment month for PGY2’s

- CBT
- Motivational Interviewing
Evaluation

- Round table self and group every 6 months
- Individual evaluation every 6 months
- Formal written evaluations of residents and tutors
Evaluation

- Individual evaluation every 6 months
- Involves resident, bs tutor, and family medicine supervisor
- 50% attendance.
- 2 +2 rule, every 6 months
- Must pass “BS” to write the exam. Treated as ‘seriously’ as any other rotation
New Evaluation Forms and Process

- Resident evaluations
  - Four Principles of Family Medicine
  - Reflects objectives of the BS program
  - Formative and Summative
  - Summative based on expectations for level of training
  - Honours longitudinal program
  - Supervisor - larger role
  - Tutor responsible for evaluating tutorial
  - Educational Planning - resident, tutor, supervisor
New Evaluation Forms and Process

- Tutor Evaluation
  - Timely and accurate
  - Formative and summative
  - Incorporates feedback from all residents
  - Honour longitudinal relationship of tutor/resident
  - All tutors evaluated using same form
Funding

- McMaster FHT
- Sessional funding for psychiatrists
- Funding for counselors
Conclusions

- DFM Accreditation Report, April 2009

- Behavioural Sciences “…particularly noteworthy strength of the residency program….unique and effectively meets the needs of the residents.”
## Conclusions

### 2007-2008 End of year questionnaire SFHC PGY2

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<th>Overall Evaluation</th>
<th>Very Useful</th>
<th>Neutral</th>
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Conclusions

2007-2008 End of year questionnaire SFHC PGY1

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NORTHERN CONNECTIONS
MEDICAL CLINIC/PSYCHIATRY
COLLABORATIVE TEACHING PROJECT

Shared Mental Health Care in Collaboration with
The NCMC Family Medicine Training Centre
Winnipeg, Manitoba
CONTRIBUTORS

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  - Research Associate, Dept of Family Medicine, U of Manitoba
  - Assistant Professor, Dept. of Psychiatry, U of Manitoba
  - Medical Director of Community Mental Health, WRHA
NCMC/PSYCHIATRY
TEACHING MODEL

Participants:

- FM Residents
- PGY-4 Psychiatric Resident(s)
- Psychiatrist
- Shared Care Mental Health Counsellor
- Patient(s)
- NCMC Family Physicians
- [Psychologist - potentially]
Consultation Mode:
Post-consultation reflection:
DIDACTIC TEACHING: Collaborative & Reflective

- Facts
- Stories and/or Case Review
- Discussion/Questions
- Management
INTERVIEWING: Collaborative & Reflective

- Family Resident starts
- PGY-4 wraps up
- Psychiatrist completes
- Reflective Session Begins
  - Invite the patient to sit in as audience
  - Discussion and Reflections of Strengths & Strategies amongst the interviewees and the counsellor (who joins from behind the mirror).
  - Conclusions and Plan of Action
  - Feed back from Patient who then leaves
- Review of interview content/technique and unique aspects of the particular presentation.
- Review with the Family Physician
A Patient’s Perspective

- Found the collaborative – reflective experience most helpful:
  - “I’m not fed bullshit.”
  - Thought has been taken in working out options
  - If one thing doesn’t work then we’ll try another
  - Not just given what comes to mind
  - Compassion
STUDY DESIGN

Philosophy of Providing Mental Health Care

Competencies in Mental Health Care:
1. Identification
2. Interviewing Skills
3. Management
4. Medications
5. Collaboration

Recognition (Knowledge)

Acceptance (Attitudes)

Application in Practice (Behaviour & Skills)

Philosophy of Collaborative Practice

Core Competencies in Collaborative Care:
1. Role Clarity
2. Communicator
3. Collaborative Leadership
4. Team functioning
5. Pt/Family Centered Care
6. Conflict Resolution
STUDY DESIGN

Capacity to Treat Mental Health Clients

- KSA pretest/survey
- KSA test; Q interviews
- KSA; Q interviews Comfort + Intention
- Application in Practice

Collaborative Practice

- KSA pretest/survey
- KSA test; Q interviews
- KSA; Q interviews Comfort + Intention
- Application in Practice

Incoming R1s

- NCMC Psych Teaching
- Integrate teaching and real world experiences

R1 year-end

R2 year-end

Application in Practice
<table>
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<tr>
<th>Competencies</th>
<th>Exposure: Introduction</th>
<th>Immersion: Development</th>
<th>Mastery: CPD</th>
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<tbody>
<tr>
<td>Interpersonal &amp; Communication Skills</td>
<td>Knowledge</td>
<td>Skills</td>
<td>Behaviour</td>
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<td>Person-Centred &amp; Family Focused Care</td>
<td>Knowledge, Attitudes</td>
<td>Skills</td>
<td>Behaviour</td>
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<td>Collaborative Practice Decision Making</td>
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<td>Collaborative Practice Roles &amp; Responsibilities</td>
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<td>Collaborative Practice Team Functioning</td>
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<tr>
<td>Collaborative Practice Continuous Quality Improvement (CQI)</td>
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TOOLS:

- Already have:
  - Family Medicine-Psychiatry Questionnaire

- Need to develop:
  - Knowledge test re: Six Core Competencies in Collaborative Practice
    - (have permission to use Dr Grymonpré’s MCQ test)
  - Assessment of Competencies in Mental Health Care
  - Stigma Awareness
  - Post-graduation survey
  - ?? Any other suggestions
NEXT STEPS...

- Review ‘pilot survey’ info
- REB proposal
- Review Evaluation options
- Shared Care Evaluation Survey Review
Using Video in Clinical Supervision

- Help learners become comfortable
- Tape all their encounters
- Tape regularly
- Get consent on tape
Using Video in Clinical Supervision

- Give constructive feedback in a supportive manner
- “McMaster Sandwich”
- Resident to resident feedback important
Using Video in Clinical Supervision

- Presenter gives a preamble
- States learning objectives
- They can decide which specific parts of the tape are important to watch
- Can re-edit if possible
- Presenter keeps remote control
- Any person in the group can stop tape
- Encourage frequent stops
Using Video in Clinical Supervision

- Ask the resident who is presenting for their reflections and ideas
- Then ask other residents
- Then facilitators may speak up
Using Video in Clinical Supervision

- Can ask about attitudes
  - What were you feeling, thinking?
  - What is another way of saying that?

- Can look for non-verbal cues
  - Using silence
  - Making “empathic statements”
Using Video in Clinical Supervision

- Can help develop efficient information gathering skills
- Use of open and closed questions
- Can help develop exact questioning for making psychiatric diagnoses
- Can use the case to get into treatment issues, content issues
Using Video in Clinical Supervision

- Modeling can be helpful
- Facilitators may show their own tapes
- Residents can then critique facilitators
- Showing a tape that did not go well is highly useful for teaching
Using Video in Clinical Supervision

- Try to review the tape as soon as possible from the time of taping
- Residents can then remember more of the issues that were involved in this presentation
Using Video in Clinical Supervision

- Prioritize tapes at the beginning of a session
- Clinical questions take priority
- Let the group decide which tapes may be most appropriate
- Choice also made on viewing particular residents
Using Video in Clinical Supervision

- Log is kept with resident presentations
- Try to ensure that each resident shows the required number of tapes
Using Video in Clinical Supervision

- Non-judgmental supportive critique
- Develop a trusting relationship in which learners feel comfortable with vulnerability
- Be respectful and straightforward
Using Video in Clinical Supervision

- Be specific in feedback, e.g., here is how one could ask these specific questions versus “good interview”
Using Video in Clinical Supervision

- Avoid overloading the learner with feedback
- Get the presenter’s reaction to feedback they have received
Using Video in Clinical Supervision

- Advantage of this system: Residents can learn from other people’s cases
- An example of this is teaching CBT where we watch one resident with an ongoing case
Using Video in Clinical Supervision

- Use case as platform to explore treatment, epidemiology, personal responses (transference and countertransference) communication
Reference

USING VIDEO IN CLINICAL SUPERVISION

- Lights, camera, action......
emails

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