No psychiatry?

Assessment of family medicine residents' training in mental health issues

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ABSTRACT

OBJECTIVE To assess whether the mental health component of the family medicine residency program at Memorial University of Newfoundland, which contains no formal mental health training with psychiatrists, adequately prepares residents for practice, and to assess which aspects of their training enhanced their mental health skills most.

DESIGN Cross-sectional mailed survey.

SETTING A 2-year family practice residency program with a focus on training for rural practice offering integrated and eclectic multidisciplinary mental health training rather than formal psychiatry experience.

PARTICIPANTS Graduates of the family practice residency program, 1990 to 1995. Completed questionnaires were returned by 62 of 116 physicians.

MAIN OUTCOME MEASURE Confidence of respondents in dealing with 23 mental health problems.

RESULTS Respondents felt prepared to address most of the mental health needs of their patients. Higher levels of confidence were associated with lower referral rates. There was no significant relationship between time spent in practice and confidence in dealing with mental health problems. Graduates' confidence correlated with areas in the program identified as strong.

CONCLUSIONS The program appears to train family doctors effectively to meet the mental health needs of their patients.

RÉSUMÉ

OBJECTIF Déterminer si la composante pédagogique sur la santé mentale dispensée dans le programme de résidence en médecine familiale de l'Université Memorial de Terre-Neuve, qui ne comporte aucune formation formelle avec des psychiatres, prépare suffisamment les résidents pour la pratique et évaluer quels aspects de leur formation a perfectionné le plus leurs compétences en santé mentale.

CONCEPT Un sondage ponctuel envoyé par la poste.

CONTEXTE Un programme de résidence en médecine familiale d'une durée de deux ans se concentrant sur la pratique rurale et offrant une formation en santé mentale intégrée, multidisciplinaire et éclectique plutôt qu'une expérience formelle en psychiatrie.

PARTICIPANTS Les diplômés du programme de résidence en pratique familiale de 1990 à 1995. Un total de 62 médecins sur 116 ont retourné le questionnaire rempli.

PRINCIPALES MESURES DES RÉSULTATS Le degré de confiance des répondants dans la prise en charge de 23 problèmes de santé mentale.

RÉSULTATS Les répondants se sentaient prêts à répondre à la majorité des besoins de leurs patients en matière de santé mentale. Les degrés élevés de confiance étaient associés à un moins grand nombre de cas aiguillés. Il n'existait pas de rapport significatif entre le temps passé en pratique et la confiance à l'égard de la prise en charge des problèmes de santé mentale. Il y avait une corrélation entre le degré de confiance exprimé par les diplômés et les composantes identifiées comme des forces du programme.

CONCLUSIONS Le programme semble former efficacement les médecins de famille pour répondre aux besoins de leurs patients en santé mentale.

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The family practice residency program at Memorial University of Newfoundland (Memorial) has a stated mandate and a national reputation for training family physicians for rural and remote practice. The program capitalizes on the unique characteristics of the region that permit frequent and extended learning opportunities in rural settings.

The philosophy of our program is that family medicine itself is a discipline with the expertise to train its graduate students in mental health issues. This contrasts with the more traditional model of deferring this teaching to the discipline of psychiatry.

We believe that by using this model we demonstrate the central role of family doctors in addressing mental health issues with all their patients. It is vital, we believe, that family physicians recognize the expertise within themselves, while at the same time using the support of other disciplines to enhance and share this care.

This unique curriculum was developed with the recognition that graduates could be practising relatively autonomously, often far from psychiatric services. Behavioural medicine issues and skills are taught predominantly by family physicians. There is no formal psychiatry experience, and opportunities for learning behavioural medicine and psychiatry evolve from clinical exposure in family medicine. In addition, close liaison with colleagues in counseling psychology means residents have the opportunity to better understand their role as mental health resources to their patients.[1-5]

Behavioural medicine and psychiatry training emphasizes the interpersonal and communication aspects of mental health care and provides trainees with opportunities to learn and understand the wider social and economic context, such as the effect of violence, unemployment, and poverty on the mental health of their patients.[6] Residents also get intensive training in emergency management of psychiatric problems in rural settings.[7]

Family medicine residency programs across Canada vary in their approaches to teaching mental health issues. Some combine seminars or other innovative approaches (Balint seminars, liaison psychiatry) with clinical rotations in psychiatry. There are, however, few published evaluations of the effect of these programs on their graduates once in practice.[2] Because our program does not provide traditional training in psychiatry, it is important that we evaluate whether the family physicians trained at our institution perceive that their mental health skills are adequate for practice. The following study addresses that issue.

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METHODS

We developed a survey instrument to evaluate the effectiveness of our mental health training. It was modeled on one used in a similar study.[2] It sought both quantitative and qualitative information on the type of mental health issues these physicians encountered in practice and their perception of how their residency education prepared them to address them. The questionnaire was refined in consultation with family medicine faculty and was mailed to all 116 family physicians who graduated from Memorial's family practice residency program between 1990 and 1995. There was only one mailing, and replies were anonymous.

Three demographic questions asked number of years in practice, number of patients with mental health issues seen each week, and which undergraduate program physicians had attended. Descriptive statistics were used for these questions. Respondents were then asked to rate themselves on a 10-point Likert scale as to their confidence to manage various mental health problems (**Table 1** lists the 23 problems). For each problem, respondents were also asked to indicate whether they would refer this particular problem and the reason for referral.

Comparisons between mean confidence levels and referral rates were made by analysis of variance, as were comparisons between years in practice and confidence level in dealing with the issues. χ^2 tests were used to relate referral rates to doctors' experience in practice. All quantitative analyses were done using SPSS for Vax.[8] Levels of $\alpha = 0.05$ and $\beta = 0.2$ were used.

Seven open-ended questions explored respondents' opinions on which mental health issues had been well covered in residency training, how residency training could be improved, and how continuing medical education for established physicians could best address mental health issues. Theme analysis

was used to consider the replies to these questions. Two of the authors independently analyzed the data. They identified dominant and recurring themes in replies to each question and across questions. There was a great deal of overlap between the two analyses, and together the authors constructed a list of shared themes.

RESULTS

Completed questionnaires were returned by 62 (53%) of the 116 doctors surveyed. These doctors had been in practice from 6 months to 5 years. Among the respondents, 39% were recent graduates (less than 2 years since residency), and 61% had been in practice for more than 2 years; 56% were Memorial undergraduates, and 44% were graduates from other medical schools. Number of patients with mental health problems seen per week ranged from none to 25. Most doctors (56%) estimated they saw between six and 20 patients per week with such problems. About one third (37%) saw five or fewer mental health patients each week, while only a small number (7%) encountered more than 20 such patients per week.

Depression (58%) was the most common problem seen, while violence (including wife assault and sexual abuse) was the next most frequent (38%). Other frequent problems included anxiety (25%), addictions (22%), and grief and bereavement (13%). The more confident respondents felt in dealing with a problem, the less likely they were to refer patients, and vice versa (**Table 1**). Level of confidence was significantly associated with referral rate for the following problems: learning disorders (*P*.037), sexual problems (*P*.006), problems with parenting (*P*.004), depression (*P*.004), panic disorders (*P*.04), loss and bereavement (*P*.01), suicidal ideas (*P*.04), dementia (*P*.005), and certification (*P*.03).

For all nine problems, the mean confidence level was lower for those who referred than for those who did not. When specifically asked, respondents stated their reasons for referral: presence of good community resources (43%), lack of skill (35%), lack of time (11%), personal difficulty with the problem (2%), and other reasons (11%). Doctors' length of time in practice was not related to level of confidence, ie, doctors did not seem to become more confident over time in dealing with mental health problems. Doctors with more experience, however, were more likely to refer patients with marital problems than were more recent graduates (*P*.018).

Table 1. Physicians' confidence in handling 23 mental health issues

ISSUE	MEAN CONFIDENCE LEVEL ± SD	REFERRAL RATE (%)	PROBABILITY BY ANOVA*
Death and dying	8.2 ± 1.2	0†	—
Depression	8.2 ± 1.2	11.5	0.004*
Giving bad news	8.0 ± 1.4	0†	—
Loss and bereavement	7.9 ± 1.5	1.6	0.01*
Suicidal ideas	7.6 ± 1.4	29.5	0.04*
Anxiety	7.3 ± 1.4	6.6	0.95
Alcoholism	7.2 ± 1.6	23.0	0.07
Dementia	7.2 ± 1.5	16.4	0.005*
Panic disorder	7.1 ± 1.6	6.6	0.04*
Certification	7.1 ± 1.9	39.3	0.03*
Parenting	7.0 ± 1.8	9.8	0.004*
Addictions	6.9 ± 1.5	37.7	0.32
Crisis intervention	6.9 ± 1.5	19.7	0.14
Sexual assault	6.9 ± 1.7	44.3	0.29
Marital and relationship problems	6.8 ± 1.6	31.1	0.05
Child protection	6.7 ± 1.7	55.7	0.18
Wife assault	6.7 ± 1.8	34.4	0.19
Sexual problems	6.7 ± 1.7	23.0	0.006*
Somatization	6.3 ± 1.6	6.6	0.17
Attention deficit disorder	6.0 ± 1.9	70.5	0.1
Schizophrenia	5.7 ± 1.9	75.4	0.73
Child sexual abuse	5.6 ± 2.1	70.7	0.75
Learning disorders	4.5 ± 1.7	75.4	0.037*

**Analysis of variance (ANOVA) ≤ 0.05.*
†*Because the referral rate was 0, ANOVA was not possible.*

Overall, feedback about the mental health training provided at Memorial, both as to the skills acquired and the experiences during training, was positive. Many respondents commented that it is one of the strengths of the Memorial family practice program. When asked what specifically developed their ability to address mental health problems, they identified the emphasis on communication skills, their experiences in rural settings, and their experience at the university counseling centre, where counseling

psychologists formally teach counseling skills in a seminar program.

Respondents ranked their training in dealing with death and dying as the best learning opportunity and thought that the program gave them exemplary skills in this difficult area: "Almost every day I'm thankful for the learning I had in palliative care." They ranked their training in depression and anxiety highly and also felt they had received good training in dealing with violence. They referred to both the seminars and hands-on experience of participating with faculty as part of the local sexual assault assessment team: "The greatest strength in the training program is education about violence." "I'm way more comfortable than my peers in dealing with wife abuse and sexual assault." The opportunity to learn and test their skills in rural settings was captured by one respondent with the comment:

> Experience one-on-one with patients in Memorial's program made one realize that the buck stops here in rural practice, and we were given the opportunity to rise to the occasion and to treat.

Respondents identified several areas that could be improved in the training program. They suggested increasing opportunities to work with other mental health professionals; adding training in child and adolescent mental health in areas such as attention deficit disorder, learning disorders, adolescent suicide, and child sexual abuse; training in marital relationship problems; and training in dealing with major psychiatric disorders. Many respondents commented that there should be a greater emphasis on psychotherapy and counseling skills and that they felt constrained by their lack of knowledge about and experience with counseling and psychotherapeutic techniques.

DISCUSSION

This is one of the few studies that actually looks at graduating physicians' perceptions of how well prepared they are to deal with mental health issues in practice. No programs have reported on physicians' confidence in practice once their graduates have had the opportunity to experience real practice, although the study by Brown and Weston[2] at the University of Western Ontario used respondents' level of satisfaction with their skills in psychosocial issues as their measure. Most often, analysis occurs with just-graduating residents and their perception of readiness before they actually enter practice or through surveys of practising physicians who might not really know what role their residency training played in development of their mental health skills.[9-11]

Our non-traditional mental health program, which was developed using predominantly family medicine resources, clearly leaves graduates with a sense of competence to address most of the mental health problems they encounter in the first 5 years of practice. Since there are no data on the confidence of graduates from more traditional programs, we cannot say whether our training does a better job. From our data, however, it appears that graduates of our program feel well prepared. This supports the notion that mental health issues are integral to the practice of family medicine. Using the experience and expertise of family medicine teachers, in consultation with colleagues from other disciplines, we have developed a behavioural medicine program that prepares family doctors to manage the mental health needs of their patients.

Issues that were specifically taught in the program, such as death and dying, depression, giving bad news, loss and bereavement, and violence, were the areas in which respondents had the greatest confidence. Conversely, respondents had less confidence in dealing with attention deficit disorder, schizophrenia, child sexual abuse, and learning disorders. Whether these areas need more curriculum time or the focus changed to appropriate referral strategies needs further consideration.

An important issue that emerged from this study was that respondents wanted to have a deeper understanding of psychotherapy and the skill to do more in-depth counseling with patients. Many suggested they would like to enhance their mental health skills now that they are established in practice. Whether these skills are most appropriate for continuing medical education or for residency training is worth further research.[1,6,10,12] This issue has important ramifications for our training program and challenges us to create an environment where some of those skills can be honed.

Our study had some limitations. The characteristics of nonrespondents cannot be identified. Our conclusions are, therefore, based on the 53% who responded. Despite this, we received valuable information about the components of our diverse, eclectic, and non-traditional behavioural medicine and psychiatry curriculum that can lead to improving the program. In response to the results of this survey, we have adapted our curriculum to address the deficiencies identified in our program.

Key points

- Memorial University of Newfoundland's family medicine program does not use formal teaching by psychiatrists for its mental health training. It relies instead on the skills of counselors and family physicians.
- This survey assessed how well prepared graduates felt to handle the mental health problems they faced in their mostly rural practices.
- Overall, respondents felt well prepared for most mental health problems, in particular, those emphasized during training.
- Referrals were inversely correlated with family physicians' confidence to manage problems and not with their length of time in practice.

Points de repère

- Le programme de médecine familiale de l'Université Memorial n'a pas recours à un enseignement formel par des psychiatres pour sa formation en santé mentale. Il compte plutôt sur les compétences de conseillers et de médecins de famille.
- Cette étude évaluait chez les diplômés, leur état de préparation à l'endroit de la prise en charge des problèmes de santé mentale auxquels ils ont dû faire face dans leur pratique majoritairement rurale.
- Dans l'ensemble, les répondants se sentaient bien préparés pour la prise en charge de la plupart des problèmes de santé mentale, en particulier ceux sur lesquels on a insisté durant leur formation.
- Le nombre d'aiguillages était inversement proportionnel au degré de confiance des médecins de famille pour traiter les problèmes plutôt que lié à la durée de la pratique.

We have created a curriculum guide that integrates the various components into a course outline. Each component has more clearly stated goals that pertain to our overarching objective of training family doctors to work in rural and semi-isolated areas. The guide is designed to assist learners to anticipate where particular skills and knowledge will be gained in their training. We have added a journal component where residents reflect on critical incidents in their training. The goal of the journal is to stimulate residents to reflect on the challenges they encounter with mental health issues during training.

CONCLUSION

Mental health and behavioural medicine training is indeed a strength of our residency program. This survey demonstrates that graduates of our non-traditional program have reasonable levels of confidence in dealing with most mental health issues. This survey supports our long-standing philosophy of integrating mental health issues throughout residency training. In each of our curriculum experiences, we capitalize on the skills of family physicians in collaboration with other mental health professionals within the community.

The nature of the mental health work that family doctors do in the community differs from that of psychiatrists.[3,4,12-16] It is a challenge for family medicine to define more clearly how family physicians can best address the mental health problems faced by their patients.[3,4,15,17] Our goal is to better train family doctors to be mental health resources to their practice communities. We will continue to adapt and enhance our innovative strategies.

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