THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Canadian Psychiatric Association

Dedicated to quality care

Association des psychiatres du Canada

Dévouée aux soins de qualité

Mental Health RESOURCES

DECEMBER 2017

Mental Health Resources

Table of Contents

Introduction ... 3
Acknowledgements ... 3
The Roles of Primary, Secondary, and Tertiary Care for Mental Health and Substance Use Disorders ... 4
Improving Access to a Psychiatrist ... 7
Assessing and Improving the Mental Health Friendliness of Your Family Practice ... 9
Informing and Training Support Staff to Assist Patients with Mental Health and Addiction Problems ... 11
Supporting and Managing Individuals and Families with Education and Information ... 12
De-escalating Conflict in the Primary Care Office ... 14
Mental Health and Timely Access to Primary Health Care ... 18
Preparing a Patient for a Visit ... 20
Using the Experience of Patients to Provide Better Care ... 21
Improving the Management of Individuals with Depression in Your Practice ... 22
Preparing a Patient for Psychotherapy or Counselling ... 25
Self-Reflection for Primary Care Providers Delivering Mental Health Care ... 27
Reducing Mental Health Stigma in Your Practice ... 29
Scheduling Visits for People with Mental Illness ... 32

Introduction

The Collaborative Working Group on Shared Mental Health Care (CWGSMHC), a conjoint committee that includes representation from the College of Family Physicians of Canada (CFPC) and the Canadian Psychiatric Association (CPA) is pleased to offer this practical resource for family physicians to assist with the care of patients with mental health issues in their practice. Supporting and caring for people with mental health concerns is an integral part of our work as family physicians and we've offered practical tips and solutions that have worked for us and other busy practitioners. We also need to be mindful of our own mental health within the context of our busy practices. We invite your comments and recommendations at mentalhealth@cfpc.ca for consideration in the next iteration of this resource.

Acknowledgements

Special thanks to the experts who contributed to the creation of this document, including:

- Dr. Ellen Anderson
- Dr. Roger Bland
- Ms. Maureen Desmarais
- Dr. Michel Gervais
- Dr. Marie Hayes
- Dr. Nick Kates
- Dr. Patricia Mirwaldt
- Dr. Victor Ng
- Dr. Chris Toplack
- Dr. Tom Ungar
- Dr. Vicky Winterton

The Roles of Primary, Secondary, and Tertiary Care for Mental Health and Substance Use Disorders

Increasingly, jurisdictions around the world are recognizing that improving links between mental health (MH) and primary care (PC) services and providers, and clearly defining their respective roles within an integrated network of mental health services can improve access, reduce wait times, provide additional support for primary care providers, improve communication and co-ordination of care, lead to better outcomes for patients, and enhance a person's experience of seeking care. This has been promoted by the World Health Organization (WHO).

General statements from the WHO

- The burden of mental disorders is great
- Mental and physical health problems are interwoven
- The treatment gap for mental disorders is enormous
- Primary care for mental health enhances access
- Primary care for mental health reduces stigma
- Primary care for mental health is affordable and cost-effective
- Primary care for mental health generates good health outcomes
- Integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental health care they need
- There is no single best practice model
- Holistic care will never be achieved until mental health is integrated into primary care
- Adequate training of primary care workers is required
- Primary care tasks must be explicit and doable
- Specialist mental health professionals and facilities must be available to support primary care

Integrated care, collaborative care, and shared care

While these terms are used interchangeably, integrated care is taken to mean the full integration of mental health services within primary care, and collaborative or shared care is seen as being provided by two or more different services that work closely together.

A similar approach identifies five different kinds of collaborative activity between mental health and primary care services. These are:

- **Communication:** MH and PC providers exchange information more efficiently or regularly
- **Consultation:** MH care providers give an opinion on a problem or care options
- **Coordination:** MH and PC providers work together to develop a single integrated treatment plan
- **Co-location:** MH providers work in the same building or office as a primary care physician or practice

- **Integration:** MH providers work in a primary care practice as part of the primary care team

Potential roles of care in a well-integrated mental health care system

Primary level

Primary care is often the first point of contact for someone with a mental health or addiction problem. Providers may have an enduring relationship with an individual and their family. Primary care is uniquely positioned to:

- Provide health services for all health concerns, whether emotional or physical
- Identify and manage mental disorders, problems with substance use, and emotional and psychological crises
- Identify patients who require secondary- or tertiary-level care
- Identify and manage patients whose physical problems indicate underlying psychological issues
- Identify individuals who may be at risk because of loss, trauma, or stress
- Provide education for individuals and the community on maintaining good mental health
- Ensure that patients referred back from secondary and tertiary care facilities receive appropriate follow-up, treatment, and monitoring
- Develop and provide guidance on activities, exercise, weight control, relaxation, and diet under more generic health-promotion activities
- Help organize and mobilize support and self-help groups, usually involving voluntary and community agencies
- Coordinate care, initiate referrals to more specialized services, and help individuals navigate the system
- Offer family interventions

Increasingly, primary care is delivered by a team of health care workers who may be more or less specialized in providing some of the services listed above.

Secondary level

To support these roles, mental health services must:

- Provide rapid access to consultation and advice
- Diagnose, treat, and follow up with patients, including those referred from the primary care level and who require more comprehensive services than can be provided at the primary care level. This will likely include both in-patients and out patients and, in many instances, day (partial hospitalization) and group programs of various kinds.
- Prioritize those people who cannot be managed in primary care (complexity/lack of resources) and provide ongoing care
- Support primary care services through arrangements such as providing collaborative care, teaching, and referral systems

- Provide emergency services in general hospitals that have adequate capacity for mental health and substance use problems
- Provide crisis services to support primary care that the community will directly access. This may also require short-term-crisis beds
- Provide general in-patient psychiatric services to all types of patients requiring psychiatric hospitalization
- Provide information about and link with community resources
- Provide continuing education for and support of primary health care services
- Liaise with other relevant health sectors both in the community and in hospitals—this includes assistance with housing, income support, employment, recreation, and other supportive programs
- Use various treatments for mental disorders and substance use including medications, psychotherapy, social activation, and family interventions

It is likely that practitioners at this level will be working as part of a comprehensive team of specialized mental health workers.

Tertiary level

This generally refers to qualified psychiatric personnel working in specialized mental health facilities, which may be community-based or part of a general or psychiatric hospital. Such facilities, which are frequently teaching institutions, are prepared to deal with complex problems of diagnosis and treatment referred from the primary and secondary levels. They are frequently responsible for organizing training for various aspects of mental health, may have supervisory responsibilities for secondary care level services, and may undertake research and evaluation. Tertiary ambulatory services can include case management and assertive community treatment programs for those with chronic mental disorders who have difficulty functioning in the community.

A substantial proportion of the diagnosis and treatment of mental disorders can be handled at the primary and secondary care levels, which is usually more convenient and often less stigmatizing for the person. More complex diagnostic and treatment problems may require tertiary level resources.

The concepts of chronic disease management and stepped care apply to those with mental health and substance use problems.

Improving Access to a Psychiatrist

Get to know some local psychiatrists

Meet local psychiatrists at continuing professional development programs, hospital rounds, or clinical service meetings of many kinds. Find out the scope of their practice and whether they are taking referrals. Be aware of the health care policies promoting access to a psychiatrist in your territory and use levers at hand to implement them. Many health care authorities support networking between psychiatric services and family medicine clinics, and a preliminary phone call may also increase the likelihood that a referral will be accepted.

When you refer a patient for a psychiatric consultation, write a helpful letter

One or two comprehensive paragraphs should be enough to provide relevant background information, including previous treatments and responses and the questions you would like the consultant to answer. Here is an example:

> "Thank you for agreeing to see this 34-year-old happily married housewife, mother of two teenage sons. Her mother died two months ago (she was the principal caregiver for her mother), since when she has developed symptoms of depression with sleep problems, loss of appetite, lack of energy, and feelings of guilt that she did not do enough for her mother and that she is an inadequate mother for her boys. She did have a brief episode of postpartum depression following the birth of her second son but this resolved spontaneously.
>
> One month ago I placed her on citalopram 20 mg daily and she has been compliant with this without side effects, but the response has been only partial. I would very much appreciate your assessment and advice regarding further management. Should I increase the dose of citalopram, change antidepressants, or augment? We also have a psychologist attached to the practice who could see this patient for supportive or cognitive behavioural sessions if you feel this is indicated at this stage."

Be clear about why you want your patient seen and your expectations for the referral

You may be seeking an opinion on diagnosis, recommendations for treatment, or access to a more specialized program. Give some idea of the urgency of the referral. Provide indications about the medical follow-up, whether it is that you will take it upon yourself, that you want a joint follow-up with the psychiatrist, or a transfer to a specialized program. If the patient will likely be treated by psychiatric services, ask to be kept informed of progress.

Beyond the traditional requests for consultations as described above, consider establishing more sophisticated collaborative care with one or more psychiatrists

Your primary care network or group may already have an arrangement with psychiatrists sharing ongoing responsibility for care. If so, get to know them and take advantage of this arrangement. If not, work with your colleagues to develop such an arrangement, preferably with someone who is willing to

include telephone contact and advice to your group. The psychiatrist's contribution can take many forms: "lunch and learn" rounds, where the members discuss challenging problems you are facing; supervision of professionals on your staff; liaison with the department of psychiatry; information on local services or the current literature; or assistance with implementing clinical guidelines. Build those collaborative care arrangements in easy stages and begin with the most promising initiatives. Work with your local health authority or provincial/territorial health services to access funding for these arrangements where possible.

Pay attention to the quality and the efficacy of the communication between the family physicians and the psychiatrist(s)

Several communication methods may be used: telephone contacts and advice, emails, periodic visits by the psychiatrist to the family medicine clinic, telehealth, etc. Some models plan the co-location of psychiatrists' services with those of family physicians.

If your network or group employee has an arrangement with counselling and/or social work services, let the psychiatrists know what you can offer for support or psychotherapy services after a consultation.

Assessing and Improving the Mental Health Friendliness of Your Family Practice

Assess your existing practice structures and processes

Many patients with mental health challenges feel their concerns might not be legitimate issues for their family doctor's attention, or may feel uncomfortable asking for mental health care in their family doctor's office. Here are a few key activities to ensure your office is accessible and responsive to patients with mental, as well as physical, health concerns:

- Take a step back, look at what is working well and what needs attention
  - Ask staff and patients for feedback. This will allow you a better perspective on how things are currently working and how they might be improved.
  - Offer a short, anonymous, three- or four-question practice survey featuring open-ended questions. This is simple for both staff and patients to complete, and can generate excellent information in a brief time frame.
  - Consider a small focus group of interested patients. This gives them the opportunity to offer suggestions in a safe setting, and can generate useful information and suggestions for improvement.

- Think about your office processes, which can include:
  - How your telephone triage works
  - How you book same-day and urgent appointments
  - How much time you book for patients with MH concerns
  - What wait times are for patients referred for psychiatric care, and what services can be provided while they wait
  - What other supports for patients with MH concerns exist in your practice or your community

- Ask your office staff how they feel when working with patients with mental health and addiction problems:
  - Are you comfortable doing telephone/front desk triage for patients with mental health or emotional problems?
  - How well trained do you feel to work with patients who wish to book an appointment for a mental health problem?
  - What skills do you feel you need to acquire to be more comfortable dealing with a patient with mental health or addiction concerns?

- Ask your patients about their experiences:
  - How do you communicate with your doctor's staff when booking an appointment for mental health or emotional issues?
  - Do you feel comfortable speaking with your family doctor if you have emotional or mental health problems?

    - What could our office do to improve your experience when you come to us with mental health issues?

- Place a suggestion or comments box in your waiting room or on the counter; this can generate useful information
- Routinely include one or two questions about mental health issues or alcohol consumption in your comprehensive assessments, chronic disease follow-up care, complex care planning for elderly patients, youth health care, well-teen visits and other care. This normalizes the inclusion of mental/emotional, as well as physical, concerns in practice
- Use specific rating scales and symptom scores such as the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder 7 (GAD-7), which are easily accessible and can save you time and help avoid unexpected surprises
- Proactively ask patients about their mental health; this legitimizes their concerns. This can save you time, allow you to better plan their care, and book their appointments. "Are there any personal, family, or emotional issues that might be affecting your overall health?" is an open-ended, non-judgmental question that belongs easily in most patient encounters.
- Use visual cues to signal that your office is a safe place to address MH issues:
    - Signs or posters that champion MH issues
    - A user-friendly website or a brief practice newsletter that makes it clear that mental health and emotional issues are as important as physical concerns, and reassures patients that their concerns are legitimate
    - A sign stating that discussing mental health and addiction issues is part of your role, and an invitation to patients to raise them during a visit

Informing and Training Support Staff to Assist Patients with Mental Health and Addiction Problems

Gauging staff willingness and ability to care for people with MH problems is important in ensuring that your practice team is able to work well together under what are often stressful circumstances. Family physicians set the tone for how their practice functions. If your staff are knowledgeable, ready and willing to support patients and families with MH concerns, and you clarify what you can and cannot do in your office, you offer everyone a much healthier workplace. Ways to achieve this include:

- Scheduling in-service training for staff
- Finding out where and when your staff can do the Canadian Mental Health Association's (CMHA) mental health first aid training, and support and fund their enrollment
- Supporting all medical and non-medical staff in addressing their own biases regarding mental health issues. Regular meetings that allow staff to air concerns or make suggestions for streamlining care will decrease anxiety and provide staff with opportunities to improve their knowledge and skills.
- Listening to and acting on staff suggestions about how to improve practice flow, which will legitimize their knowledge and abilities
- Helping staff to schedule realistically, and build in time buffers for MH appointments
- Enabling staff to communicate easily with you so they understand which problems need emergency attention (i.e., same-day psychiatric evaluation or in-patient care) or urgent attention (seen by you within 24 to 72 hours), and which can be booked routinely

Supporting and Managing Individuals and Families with Education and Information

Offering up-to-date, useful, and interactive information is an important part of providing effective mental health and addiction care.

- Provide accessible and easy-to-follow information for your patients
    - Offer reliable, accessible information in your waiting room on MH topics in the form of posters, pamphlets, brochures, magazines, or other reading material
    - Consider a regular information loop if you have a TV in your office waiting area
    - Ask your patients what sorts of materials they would like to find in your waiting area
    - Offer a brief information sheet for patients on how to prepare for your office visit, which may be helpful in letting patients know what to expect
    - Locate pamphlets and information of a more personal nature in the interview rooms rather than in the waiting area, as patients may be uncomfortable picking up sensitive materials in a public area
- Use MH group sessions that focus on psychoeducation in a group setting and can destigmatize many MH concerns through education, explanation, and mutual support. Examples are programs such as Changeways, or programs offered through your local MH centre or the CMHA, or group medical visits
- Organizing reliable, evidence-based materials (either online or paper-based) that you can access easily and use to coach or support patients as they address specific challenges, such as:
    - Downloadable workbooks http://www.sfu.ca/carmha.html:
    - — *Positive Coping with Health Conditions: A Self-Care Workbook* for adults with medical challenges affecting their mood, by Dan Bilsker, Joti Samtra and Elliot Goldner
    - — *The Antidepressant Skills Workbook* for adults with depression, by Dan Bilsker and Randy Paterson
    - — *Dealing with Depression: Antidepressant Skills for Teens*, by Dan Bilsker, Merv Gilbert, David Worling and Jane Garland
    - One-page lists of reliable Internet sites that patients can access that offer information and coaching are useful to have available as handouts for patients, (e.g., Anxiety BC website)
- Think about health literacy and the importance of making sure information given to patients is congruent with their educational and literacy skills and their cultural background

Other ways to make it more likely that educational materials and instructions are read and acted upon include:

- Writing down instructions, especially for medications
- Using talkback: asking patients to tell you before they leave what they understand you to have told them about managing their health care, to ensure they have heard what you have said
- Making sure patients have a chance to ask you questions before they leave

- Ensuring websites you recommended contain the information you expect before providing the URL
- Giving patients information about problems before they come to an appointment so they can use the visit to ask any questions they might have

De-escalating Conflict in the Primary Care Office

Where and when it occurs

Over the telephone, in the waiting room, the exam room, and the emergency department—these are all locations where potential conflict can occur. When resources are constrained, patients may have difficulty getting their needs met. When a patient is new to you, there is no pre-existing understanding or relationship in place.

Why it occurs

When ill or upset, patients or family members may be frightened (e.g., their flight, fight, or freeze reactions are activated), may feel their concerns are not being dealt with in a timely manner, or that they are not being respected. The potential exists for anger and conflict in these situations.

When people feel their needs will be met, and they know what to expect, conflict is rare. Waiting for what feels like a long time without reassurance or an update on what to expect, and then to discover one's expectations cannot be met, or that necessary results or reports are not available, can give rise to frustration and anger. The keys are to predict when a situation could escalate, do whatever you can to prevent this from happening, and de-escalate a situation that has the potential to get out of control.

Preventing frustration in your practice

- Make sure that wherever possible your patients know what to expect from an appointment and are provided with updated information once they arrive (e.g., how long they will wait, when the next available appointment is likely to be, what the next steps are)
- Take a step back, listen, ask some questions, and attempt to understand their expectations; review what is possible in order to align both parties' expectations and attempt to ease frustration
- Ensure your staff are courteous, and smile and greet patients when they arrive
- Always try to look at things from the patient's/family's perspective, however frustrated you may be. It doesn't mean they're right, but this is an essential step to being able to acknowledge their concerns
- Remember, your patient's time is as valuable as yours
- Ask your staff to call or text your patients to let them know when to arrive if you're running very late
- Review patient charts at the beginning of the day and if reports or results aren't available, call the patient before they set off and ask them if they want to reschedule for a time when they are available
- Apologize to your patient if you are late or if expected resources are not available, and acknowledge the inconvenience this may have caused them

Safety in office set-up and design

- Have sufficient phone lines and staff at peak telephone times to prevent lengthy delays on hold
- Avoid situations where the office is open to foot traffic and only one staff member is present
- Have the appropriate number of staff to manage patients at your reception desk in a timely manner
- Ensure that office receptionists have a clear view of patients entering the office; they should be the first people the patient encounters
- Keep in mind that physical barriers between your reception staff and your patients, such as chest- or waist-high counters, are important, but closed windows and fully enclosed booths that limit contact are unnecessary and intimidating
- Ensure that staff advise the physician or other provider if a patient seems upset before they are seen
- Enable staff to discreetly contact physicians for support and backup in difficult situations (instant messaging, texting, etc.)
- Provide an emergency buzzer or instant message capacity in exam rooms so that physicians can call for help if necessary
- Set up exam rooms so both physician and patient have a clear path to the exit. In larger offices where patients may have difficulty finding the way out, clear signage or tape lines on the floor can help avoid confusion or panic
- Consult your provincial/territorial medical association or the Canadian Medical Association for support about smart office design when you are building or renovating
- Consider asking another staff member to join you if you are concerned about an interview with a particular patient

Recognize when things are escalating

When a person starts to argue, raise their voice, make verbal threats, or use intimidating language, it is easy to identify an escalating conflict. More challenging is the situation where someone arrives already enraged and launches into aggressive verbal or physical behaviour without any understanding on the part of staff as to why this is happening. Equally challenging are those individuals who show no sign of their rising anger until they explode, which may take staff by surprise. Careful observation of body language and facial expression may offer clues to increasing agitation or distress. If a patient arrives in an intoxicated state, you may want to postpone the visit.

Addressing escalating situations

- Don't take the bait:
  - Let go of your need to manage the other person
  - Make a conscious decision to de-escalate

- Manage yourself
  - Take a breath, slow down, speak softly, focus on this situation, and defer other distractions temporarily
  - Consider whether there is a quieter and more private place to work if you are in a noisy, busy place
  - Call for backup if you need it in order to focus on this issue
- Listen carefully and respectfully
  - Don't jump to conclusions, and avoid offering solutions before really understanding the issue
  - Acknowledge the other person's position
  - Apologize if a mistake has been made or an avoidable delay has occurred
  - Affirm that you are paying close attention to what the other person tells you
  - Clarify what you've heard
- Identify the issue
  - Try to separate the problem from the people involved
  - Ask them if they are willing to tell you what is upsetting them
  - Name the problem, externalize it, and work together to resolve it (We seem to have different ideas about … What do you think about … How can we work on this together ...)
  - Remember that everyone deserves respectful consideration
- Be open
  - Use words that indicate your willingness to work with the other person
  - Consider other perspectives (Maybe … what if … perhaps … I wonder about … it seems like … sometimes …)
- Be strategic
  - Slow down, which will give you the opportunity to reflect and think more clearly
  - Ask the patient to wait in the waiting room while you think through your strategy or approach
  - Stay focused on the patient's goals and recognize what is and is not in your power to change and what you can offer
  - Avoid all-or-nothing thinking, or seeing the situation in terms of winning or losing
- Focus on what comes next
  - Realize that you cannot change the past
  - Keep the conversation in the present
  - Look ahead to create a positive outcome
- Take a break
  - Take care of the physical changes you experience in the midst of conflict
  - Give yourself time and space to breathe and to restore your equilibrium
  - Ask for support if you need it
  - Have a process to take time out if things are not going well

- Have an emergency response plan to call authorities as a last resort

Mental Health and Timely Access to Primary Health Care

Providing timely access to appointments is central to patient-centered care and is a pillar of the Patient's Medical Home (PMH).[1] Timely and well-organized access to a personal family physician during acute episodes as well as for continuous care of persistent mental illness has been shown to improve outcomes.[2]

Different terms—including advanced access, open access, same day access, or day of choice access—are used. The goal is to provide an appointment at the time of the patient's choosing when need arises. To achieve this, a practice needs to be able to match the demand (the expected number of appointments required per week or month) with the supply (the number of appointments that the existing providers can offer). If demand outstrips supply, the practice/physician will have to find ways either to reduce the demand (e.g., ordering blood work before a visit rather than requiring a second visit to check the results, or doing more in a single visit) or to increase the supply (e.g., using other members of the team to do things previously done by the physician).[3]

The most common metric for measuring access is the time to the third next available appointment, and ideally this should be down to zero days.

To improve access, a practice needs to find ways to reduce the demand (scheduling appointments less frequently, or supporting self-management) and to increase the supply (using the time and skills of existing health professionals more efficiently and appropriately, covering multiple problems in a single visit, and improving co-ordination of available resources).[4]

This requires changes in the way an office is organized to make care processes as efficient and effective as possible. The Best Advice guide *Timely Access to Appointments in Family Practice* is an excellent reference to help with the transition to this model of care delivery.

Other ways to increase access include:

- Ensuring all practice staff are working at their full scope of practice
- Providing team-based care
- Improving collaboration with other health care specialists, including psychiatrists and mental health programs
- Improving collaboration with community agencies or services[4]

Many advanced access models recognize the need to strike a balance between pre-booked and open appointments, usually allowing for about one-third of appointments to be pre-booked and two-thirds left open.

- **Pre-booked appointments** allow the practice to define and structure care pathways for certain patients with chronic disease, and to reduce the likelihood of relapses
- **Open appointments** allow rapid access for patients with unexpected mental health problems, for patients with undifferentiated complex presentations of mental illness, and for those with severe persistent mental illness who require urgent care.[3]

A family practice open-scheduling model centred on patient needs regarding mental health should consider the following:

- Some patients may increase their care-seeking behaviour when access is no longer denied because of saturated schedules. However, in practice, knowing that the personal family physician is accessible appears to provide reassurance and cooperation rather than increasing the number of requests for appointments.[5]
- Ongoing psychoeducation, teaching validated self-management methods, and involving patients in their own care can reduce the need for appointments
- Lifestyle, sleep patterns, and decreased ability to initiate and organize requests for appointments may mean certain patients living with persistent mental illness, as well as other chronic illnesses, need regularly occurring appointment times
- Advanced access scheduling may mean family physicians are more involved in urgent care during acute episodes of illness. This challenges physicians to maintain competency, as well as establish collaborative working relationships with other mental health care professionals.

Other potential benefits of advanced access include:

- Increased family physician availability for rapid patient follow-up after an acute episode of psychiatric care outside the Patient's Medical Home
- Easier access to the family physician by mental health specialists involved in patient care for optimal or timely care of complex medical problems
- Potential increase in family physicians' capacity to participate in collaborative mental health partnerships with colleagues and patients. Integrating mental health services within the medical home team will also improve access, especially if the whole team also uses advanced access scheduling.

References

1. http://patientsmedicalhome.ca/
2. Starfield B. Primary care and health. A cross-national comparison. *JAMA* 1991;266(17):2268-71.
3. Murray M, Tantau C. Same-day appointments: Exploding the access paradigm. *Family Pract Manag* 2000;7(8):45-50
4. www.ihi.org/resources/Pages/Changes/BalanceSupplyandDemandonaDailyWeeklyandLongTermBasis.aspx
5. Murray M, Tantau C. Must patients wait? *Jt Comm J Qual Improv* 1998;24(8):423-425

Preparing a Patient for a Visit

There are a number of things you can suggest to a patient to ensure they get the most out of their visit to you or another health care provider:

- Decide the main issues that you want to make sure you talk about; if necessary, write them down. Remember that you will have limited time with your family physician during a visit.
- Ask a family member or friend to join you at the appointment, if you think it would help. You will have the specified number of minutes for the appointment, so work with your doctor to decide which issue(s) must be dealt with in today's appointment
- Make a note of your symptoms, the order in which they appeared, and anything that makes them better or worse
- Make a note of other health concerns you might want to talk about
- Bring a list of any medicines you take, including over-the-counter drugs, herbal products, and vitamins
- Bring your pharmacist's phone and fax numbers
- Keep a list of any allergies, especially medicine or food
- Keep track of how much you are eating, sleeping, and exercising
- Think about what you would like your doctor to have done by the end of the visit
- Write down any questions you want to ask
- Ask your family if they have concerns that they would like you to raise or questions they would like you to ask during the visit

Using the Experience of Patients to Provide Better Care

One of the most effective and useful ways to learn what is and isn't working in your practice and to receive suggestions for ways to improve the care you provide is to ask your patients. In most instances their feedback will focus on their experience of receiving care (issues of access, the demeanor of providers, the way information and advice was provided, the way care was organized, whether they felt respected, etc.) rather than on the specific treatments.

To be effective, a practice must commit to make changes based on what staff have heard, rather than results of a questionnaire or a focus group.

Specific ways to do this include:

- Asking each patient at the end of a visit how they think the experience could have been improved
  - Asking patients to complete a patient experience questionnaire. This may be more useful if you include questions about their ideas to improve care, ask about areas you have recognized to be problems, etc.
- Having a suggestion box for improvement ideas in the waiting area. Use signs in the waiting room to let patients know that you are interested in their feedback.
- Holding focus groups with patients once or twice a year. Someone other than the staff or health care providers in your clinic should facilitate these, if possible. This could be a general session for all patients with mental health and addictions problems or a targeted session for people with a specific problem (e.g., depression).
- Respecting confidentiality: patients invited to participate in focus groups need to be aware that other patients from the practice, whom they might know, will be present
- Holding a similar session for family members of individuals with a mental health and/or addiction problem
- Establishing a patient council. This can meet every two to three months to provide input on how the practice can improve care.
- Asking a colleague from outside the practice to do a simulated patient visit, from start to finish, and to give their impressions

Improving the Management of Individuals with Depression in Your Practice

Depression is commonly encountered in primary care. Its presentation can range from relatively mild symptoms, often in response to stress or situational change, through to symptoms that are disabling and may be unremitting or recurrent. Depression often presents with a co-existing medical condition and often goes undetected.

Whatever the origin, there are simple steps you can take to increase the likelihood that symptoms will be detected, treatment is introduced earlier and more effectively, and relapses are prevented. Some of these require changes in the way care is organized within a practice.

Monitor progress and treat to target

The most commonly used screening tool and symptom score is the PHQ-9. This is a nine-item validated questionnaire that the provider or patient can complete. It is linked to a treatment algorithm, according to the patient's score, which leads to a stepped approach to care according to the score (see below). This can be used to detect depression and also to monitor progress.

The PHQ-2 uses two of these questions, which can be incorporated into any visit and routinely asked of someone with a chronic medical condition:

- "Over the last month have you been feeling down or blue?"
- "Have you found you have enjoyed things less than you used to?"

An answer of "yes" to either of these warrants a fuller assessment of depression.

Use a stepped approach

The PHQ-9 supports a stepped approach to care. For individuals with minor or no symptoms (6–10) the first step involves healthy lifestyle activities such as diet, exercise, sleep hygiene, and ways to reduce stress. A higher score (11–15) leads to the second step and the introduction of talk therapies. The third step (16–20) involves medication and a chronic-disease-management approach. Referral to a psychiatrist should occur if these are ineffective or the patient is suicidal. The final (21) is referral to a mental health service.

Make sure there is a plan

Every patient should leave an appointment with a plan they understand, and with specific goals and the short-term steps needed to attain them. These are the patient's goals, not the provider's, and need to be easy to implement, attainable, and realistic. Achieving these can help build self-confidence.

The plan should also include the names of and contact information for the patient's caregivers (including family or other community supports), a description of their roles, a list of all medications the patient is taking, and recommendations for what to do if things aren't working.

Support self-management

Most of the time patients will be looking after their own care. Supporting an individual to make choices about their care and future, and providing them with the practical tools to monitor or implement their own care, can improve adherence to treatment and outcomes and can increase their sense of personal effectiveness and feelings of self-worth.

Provide information in an interactive way

Education and educational materials should be individually tailored and relevant to a person's culture, values, and ability to comprehend information (health literacy). It is also essential that a patient has an opportunity to discuss the information they have been given and ask any questions they may have. Family physicians can facilitate this by allowing sufficient time for questions, clearly indicating they want to hear the patient's questions (patience), and writing down information for patients as well as delivering it verbally.

Patients can also be sent written materials or directed to relevant websites to prepare themselves before a visit. They can also be given a sheet outlining ways to prepare themselves for a visit (e.g., writing down any questions they want to have answered during the visit).

Involve the family

Ask your patient who their key supports are (family, friends, neighbours, other community supports) and whether they want to involve some or all of them in a visit. This will provide an opportunity to go over treatment plans, to get a broader impression of the quality of support, the stress that caregivers may be under and the support they require, and other contextual factors the patient may have overlooked.

Reconcile medication at every visit

Try to ensure that your patient has a list of medications they can carry with them, and ask them to bring this—or the actual medications—to all appointments. This allows you to check that the patient is actually taking what you think they are and to ensure that every other specialist they see has this information, provided by the patient.

Keep a list of everyone in your practice who has a diagnosis of depression, and introduce regular callbacks

This can be easily done through an electronic medical record, as long as there is consistency in the way the diagnosis is entered, or even through a paper list. This shows you who in your practice hasn't been seen recently or had their medications renewed, and will make it much easier to call back people who aren't attending regularly. In general, a patient should be seen every six months, even when their symptoms have stabilized. Telephone follow-up—a brief call every six months—can be very cost-effective.

Preparing a Patient for Psychotherapy or Counselling

Before making a referral for psychotherapy or counselling, consider taking a few minutes to help prepare the patient for the experience. Evidence suggests that preparation and information about the process can increase the likelihood the patient will follow through with counselling.

Several factors influence the outcome of psychotherapy. The therapeutic relationship or alliance is one of the most important, along with patient factors such as life circumstances, degrees of hope and expectancy, and the therapeutic technique being used.

Giving patients information about the purpose of the referral, what to expect and what not to expect, and approximate costs or insurance possibilities in advance of the first appointment can potentially help with all of these variables. It is important to explore a patient's capacity for psychotherapy at the time of referral. Questions to consider include:

- Are there other stressors such that they will have difficulty engaging in therapy?
- Will they have the resources and the energy to get the most they can from the process?
- Would it be more productive to wait, while continuing to provide supportive care, until the patient has the resources to engage more fully?
- Is the timing right? Or right enough?

Talking realistically about what a patient can expect from therapy will go a long way to supporting their engagement. Important topics to cover include:

- The process of psychotherapy/counselling
- The challenges in talking about sometimes difficult subjects
- The need to follow through with homework if provided
- The importance of attending appointments regularly, and of regular appointments

Spending a few minutes with each patient you refer and suggesting that they clarify or write down their own wishes or goals for therapy helps them communicate with the therapist or counsellor at the initial visit and supports better therapeutic alignment.

If you are aware of the type of approach the referral clinician uses, consider providing specific information about that approach or a link to a relevant website. Your local mental health clinic may be able to provide, or advise on, pamphlets or other information about the specific therapeutic approach they use.

In summary, consider providing information to your patient before they start therapy, and consider the following:

- Talking through problems and following through with homework has been shown to help mental health problems—there is hope for change
- Counselling or psychotherapy requires time and energy, so consider whether the person can realistically engage right now

- Engaging in the process will have a big impact on a positive outcome for the patient; they can make a difference
- Providing specific educational information about the approach the counsellor may use could improve outcomes
- Counselling and psychotherapy are helpful for most people, providing positive encouragement that can engender hope
- Informing the patient that if they feel the therapy is not helping, they should raise this with the therapist

Preparing for psychotherapy can increase the likelihood of an effective therapeutic alliance and of realistic patient expectations, and can make more efficient use of this valuable health care resource.

Self-Reflection for Primary Care Providers Delivering Mental Health Care

Background

The practice of self-reflection for family physicians providing mental health care can help maintain healthy therapeutic relationships with patients. Self-reflection can help a physicians be aware of their own biases and help maintain clear boundaries.[1] Using specific self-assessment tools can assist this practice.

We all have conscious and unconscious biases and prejudices. Some of these may have an impact on patient care. Two important types of biases to consider in our work are affective and cognitive biases.

- Affective biases are unconscious emotional reactions to a patient or situation that may interfere with effective treatment. The presence of mental illness, alcohol and/or other substance abuse, poverty, cultural and sexual-identity differences, and a history of non-compliance regarding treatment are examples of situations in which patients are sometimes prejudged. The basic principles of good medical practice, beneficence, and social justice, require us to be aware of, and rectify, these biases.
- Cognitive biases are distortions in thinking that include anchoring (failure to consider more than one possibility), premature closure (uncritical acceptance of initial diagnosis), and hindsight bias (the exaggeration of the predictability of an outcome after it has occurred).

Practical Tips

Self-reflective questions (SRQs) are useful tools for physicians delivering mental health care and psychotherapy because they invite ongoing reflection of situations and patients we find difficult. You can find lists of SRQs through either the Medical Psychotherapy Association Canada or College of Physicians and Surgeons of Ontario.[2,3]

Following is a sample of SRQs and the problem area to which they relate. Take some time during a break in your working day to consider one or more of these, especially when the thought is triggered by a patient encounter:

- Do I have sufficient knowledge and skill to work with this particular patient, and if not, how can I improve?
- This relates to our competence in working with patients of all ages, gender identities, sexual orientations, cultures, etc.
- Do I seek social contact and/or encourage a degree of familiarity with my patients that is not in keeping with the professional relationship?
- This relates to the area of social boundaries.
- Do I treat patients differently if I find them physically attractive or important?

- This also relates to social boundaries and potential erotic feelings. An awareness of these issues is crucial in managing boundaries.
- Do I feel proud or gratified by being able to help a patient achieve great potential or fame, or from having clients with status? Do I want to tell others who my patient is?
- These questions reflect a type of exhibitionism on the part of the provider that, again, may lead to boundary crossings.
- Do I avoid dealing directly with patients who routinely arrive late or do not keep their appointments? Do I fear the confrontation?
- These questions relate to problems in managing potential conflict situations.
- Do I inadvertently or deliberately, in word, tone, or attitude, prevent patients from participating in the decision-making process in relation to their health care?
- This can reflect a need to control clinical situations, or a lack of respect for a patient's opinions.
- Do I feel a sense of gratification or power in being able to influence the patient with my advice or medical treatment?
- This reflects a potential unconscious or conscious desire to exert undue influence or to be needed.
- Ultimately, physicians need to consider issues that could lead them to cross boundaries with patients so that they can have trusting and mutually respectful relationships, which in turn lead to better patient outcomes. A formal method of systematic SRQs can be helpful in establishing a habit of self-reflection.

References

1. Canadian Medical Protective Association. "Overcoming bias in medical practice." *Duties and Responsibilities* Dec 2012, P1205-3-E. Available from: www.cmpa-acpm.ca/en/advice-publications/browse-articles/2012/overcoming-bias-in-medical-practice. Accessed 2017 September 11.
2. Medical Psychotherapy Association Canada. Available from: www.mdpac.ca/mental-health-professionals.html. Accessed: 2017 September 11.
3. The College of Physicians and Surgeons of Ontario. *Maintaining boundaries with patients*. CPSO Members' Dialogue. Toronto, ON: The College of Physicians and Surgeons of Ontario; September/October 2004;7-15. Available from www.cpso.on.ca/CPSO/media/images/Maintaining-Boundaries.pdf. Accessed 2017 September 11.

Reducing Mental Health Stigma in Your Practice

Background

Stigma is one of the major barriers preventing people from seeking help. Many people with mental health conditions report encountering obstacles, rejection, or abuse from family members, in the workplace, or in the wider community because of their illness. They may also feel ashamed, unworthy, and undeserving, may not tell others about what is going on, are unsure about how people will treat them, and report that the stigma is often worse than their illness. They often keep mental health issues secret (self-stigma).

The adverse effects of stigma include delays in seeking medical treatment, prematurely ending treatment, difficulty obtaining housing, adverse economic conditions, poor quality of care, and increased mortality. Within health care, stigma has been described as the primary barrier to treatment and recovery. Some 70 per cent of persons with a mental illness report that they have felt stigmatized by a family physician or other health care professional as a result of their illness.

While it's unlikely that any of us would ever purposely make a patient feel worse, ignore an illness, or discount serious conditions, we each carry prejudices and biases that can influence our behaviours and attitudes, and affect our patients' comfort and experience as well as their outcomes. That is the challenge with stigma—these behaviours and practices may be so natural and inherent to our way of providing care they may go unnoticed.

Stigma defined

Stigma is a complex social process that is the culmination of prejudice and discrimination. The ancient Greek symbol for stigma (ϛ) was tattooed, burned, or branded into the skin of people whom society wanted easily to identify as outsiders, different, and easily distinguishable from others—a mark of disgrace by which persons were socially shunned.

Stigma subtypes

- Self-stigma is the term used when people internalize public attitudes of prejudice and discrimination, with many negative effects to themselves
- Stigma by association is a phenomenon that occurs when people who provide care or services to vulnerable populations are also stigmatized by association with the group receiving care
- Structural stigma and discrimination refers to "accumulated institutional practices that work to the disadvantage … even in the absence of individual prejudice or discrimination …."[1] This "'a disabling environment'" created by the barriers to participation that reside in architecture we humans have constructed."[2]

How physicians might manifest stigma toward persons with mental illness

- Avoiding patients and denying them access to primary care
- Distancing themselves
- Showing anger at, or making negative comments to, mental health patients/care providers
- Making assumptions about someone's motives
- Blaming patients for their illness
- Showing a lack of compassion
- Providing a low quality of care; medico-legal risk-taking
- Relying on diagnostic overshadowing
- Dismissing patients' concerns or role as partners in their own care
- Showing a lack of professionalism and using inappropriate, hurtful language
- Spending less time with a person during a visit
- Not ordering possible investigations or referrals

Quality of care and medico-legal risk

Stigma can result in lower quality of care and risk to patients' health, and can also present a medico-legal risk to providers. Diagnostic overshadowing is a phenomenon in which the presence of a mental health problem blinds you to the possibility of other health and physical complaints.

Reducing stigma

- Look at how you interact with patients from different backgrounds or socioeconomic strata. Are there things you do differently? If so, explore why that might be.
- Take an online test to assess your implicit biases: https://implicit.harvard.edu/implicit/canada/takeatest.html[3]
- Manage your behaviours and the messages you send. Symptoms of mental illness can cause providers to feel fear, anger, humour, or bewilderment, as well as compassion. Remind yourself that your patient is experiencing symptoms of illness, and maintain your professional, caring, clinical stance. Don't overreact or act unprofessionally.
- Validate and accept a patient's experience of mental illness. Your doctor-patient relationship, as well as attentive listening, is a therapeutic opportunity to help patients feel better, reduce guilt, and keep them engaged in a course of treatment
- Offer information, hope, acceptance, investigations, and treatment, and direct patients to help. Your approach can ease suffering and save lives.
- Ensure you use professional language when educating and when describing a condition or talking about other mental health professionals and services
- Increase your clinical skills in mental health via continuing professional development. This increases your sense of mastery and clinical effectiveness, reduces your fear and avoidance, and has

been shown to reduce providers' tendency to stigmatize For example, see "Combating Stigma for Physicians and Other Health Professionals."[4]

- Find ways to spend time with persons in recovery from a mental illness. This has been shown to transform attitudes and reduce the tendency to stigmatize among you and your staff.
- Talk to your patients about feeling stigmatized or experiencing bias within the health care system
- Imagine how you would wish to be treated if it were you or a relative attending your office with a mental health problem
- Consider the structure and policies of your practice and whether you inadvertently discriminate against patients experiencing a mental illness. Are they accepted into care? Where and when are they seen, and for how long?
- Discuss this issue as a practice, identifying together changes you could make
- Provide equitable quality of primary care and be alert to diagnostic overshadowing. Provide routine screening and immunizations to all patients. Don't change your care or skip a physical exam or appropriate investigations just because the presenting symptoms are mental-health related, or because someone has a concurrent mental health problem.
- Advocate and educate: educate others with less health knowledge, and correct myths to reduce prejudice and discrimination

References

1. Knaak S, Ungar T. Towards a mental health inequity audit. *Lancet* 2017;4(8):583. Available from: www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(17)30281-X/fulltext. Accessed: 2017 September 11.
2. Link BG, Phelan JC. Conceptualizing stigma. *Annu Rev Sociol* 2001;27:363-85. Available from: https://campus.fsu.edu/bbcswebdav/institution/academic/social_sciences/sociology/Reading%20Lists/Mental%20Health%20Readings/Link-AnnualReview-2001.pdf. Accessed 2017 September 11.
3. Project Implicit. Implicit Association Test. Available from: https://implicit.harvard.edu/implicit/canada/takeatest.html. Accessed: 2017 September 11.
4. Mood Disorders Society of Canada. Combating Stigma for Physicians and Other Health Professionals. Available from: https://mdsc.ca/continuing-education/#Combatng_Stigma. Accessed: 2017 September 11.

Scheduling Visits for People with Mental Illness

Provide care for people living with mental illness

Family physicians often provide ongoing care to persons living with mental illness. This includes diagnosis, treatment, and follow-up for both physical and mental health and addictions problems, especially because of the increased likelihood that patients will develop significant physical health problems. A patient-centred approach to provide timely access and continuity of care requires insight, planning, and practice management.

A family physician needs to establish a balance between flexible, timely access to care and structured follow-up when needed. Coordination of actions, interventions, and services requires some planning, but the practice must also allow for unpredictable events and needs.

Planning visits

Patients living with mental illness may benefit from regular planned visits with their family physician as well as with other health care providers in the practice. Individual or group appointments can be offered. When planning each of these visits, some practical consideration merit attention, such as:

- Office staff must be well informed about time management and scheduling issues when planning mental health care appointments
- Patients' availability for appointment times may depend on sleep patterns, medication side effects, fluctuations in attention and energy, and daily routines
- Reminders and confirmation to ensure patients' attendance and participation may be necessary
- Appointments scheduled on days when members of the interdisciplinary team are present will allow for additional opportunities for collaborative interventions
- Transportation schedules may need to be considered when planning individual or group visits for this population
- Adequate time must be set aside to allow for patient-centred care as well as to achieve goals and deal with unexpected problems during the appointment
- Patient registries and recall lists will help ensure that people who live with time management and organizational challenges will not be lost to follow-up
- Emergency needs and crisis management may require that plans and schedules be set aside to deal with urgent care and safety issues