

Assessing the need for and interest in a scholarship program in children's mental health for rural family physicians

Margaret M. Steele, MD, FRCPC
Sandra Fisman, MB, FRCPC
Gordon Dickie, MB, FCFP
Neal Stretch, MD, CCFP
James Rourke, MD, CCFP
Anne Grindrod, Med Tech Dip

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[\[résumé \]](#)

Objective: To determine rural and underserved family physicians' access to child and adolescent mental health services and to evaluate interest in engaging in formal continuing medical education in child psychiatry.

Design: A cross-sectional cohort of family physicians in rural and underserved areas was surveyed with a mailed questionnaire. Initial non-responders were mailed a second questionnaire.

Setting: Southwestern Ontario

Participants: A total of 505 family physicians. Response rate was 47.9%; 242/505 surveys were completed.

Main outcome measures: Physicians' self-reported access to child and adolescent mental health services and their interest in obtaining additional training in child psychiatry.

Results: 55.4% of respondents practised in a rural location. Most (80%) family physicians felt there was a need for child psychiatry consultation visits to their community. In the majority of practices (92.5%), less than 10% of the practice involved child psychiatry. Physicians had minimal training in child psychiatry, and more than 80% did not feel confident in their knowledge and skills in managing children's mental health problems. 84.3% felt they needed more training, especially in behaviour disorders, attention-deficit hyperactivity disorder and problem adolescents. The top 3 methods respondents believed would be most beneficial for additional training were continuing medical education in the community, small group teaching by a child psychiatrist and self-instructional packages.

Conclusion: Rural and underserved family physicians would like more access to child and adolescent mental health services and more training in child psychiatry. Innovative training for family physicians in child psychiatry needs to be developed and evaluated.

Objectif : Déterminer l'accessibilité, pour les médecins de famille des régions rurales et mal desservies, des services de santé mentale destinés aux enfants et aux adolescents et évaluer dans quelle mesure une formation continue structurée en psychiatrie infantile les intéresse.

Conception : On a envoyé un questionnaire postal à une cohorte transversale de médecins de famille de régions rurales et mal desservies, et un deuxième questionnaire à ceux qui n'ont pas répondu au premier.

Contexte : Sud-ouest de l'Ontario

Participants : Sur un total de 505 médecins de famille, le taux de réponse s'est établi à 47,9 % et 242 questionnaires sur 505 ont été remplis.

Principales mesures de résultats : Accessibilité autodéclarée par les médecins des services de santé mentale pour enfants et adolescents et mesure dans laquelle une formation supplémentaire en psychiatrie infantile les intéresse.

Résultats : Parmi les répondants, 55,4 % pratiquaient en milieu rural. La plupart (80 %) des médecins de famille étaient d'avis que leur communauté avait besoin de visites d'un consultant en psychiatrie infantile. La psychiatrie infantile représentait moins de 10 % de la charge de travail de la majorité des pratiques (92,5 %). Les médecins avaient reçu une formation minimale en psychiatrie infantile et plus de 80 % n'avaient pas confiance dans leurs connaissances et leurs compétences pour prendre en charge des problèmes de santé mentale chez des enfants. Parmi les répondants, 84,3 % croyaient avoir besoin de plus de formation, surtout sur les troubles du comportement, sur le trouble d'hyperactivité avec déficit de l'attention et sur les problèmes des adolescents. Les trois principales méthodes que les répondants croyaient les plus bénéfiques pour suivre une formation supplémentaire étaient l'éducation médicale continue dans la communauté, la formation en petits groupes donnée par un spécialiste de la psychiatrie infantile et les trousseaux d'autoformation.

Conclusion : Les médecins de famille des régions rurales et mal desservies aimeraient avoir davantage accès aux services de santé mentale pour enfants et adolescents et avoir plus de formation en psychiatrie infantile. Il faut mettre au point et évaluer une formation innovatrice en psychiatrie infantile à l'intention des médecins de famille.

Introduction

There are indications that emotional and behavioural problems in children and adolescents have become more prevalent.¹ With child psychiatrists concentrated in large urban centres² the gap between psychiatric need and service provision will be magnified in rural and underserved areas of Ontario. Family physicians (FPs) could play a pivotal role in the recognition and management of child and adolescent mental health problems. The Ontario Child Health Study found that 60% of 4- to 16-year-old children identified in the survey as having a disorder had been seen by an FP in the 6 months prior to the survey.³ In addition to case finding, FPs are in a unique position to detect early parent-child problems and the impact of parental psychiatric disorders on offspring.⁴ Finally, when distressed youngsters seek advice or treatment for emotional and behavioural disorders, the majority report that they are most likely to consult an FP.⁵

Studies have shown that physicians believe their adolescent medicine training has not been ideal in psychosocial aspects.⁶ Steele and Dickie,⁷ in a survey of child and adolescent training in Canadian family medicine residency programs, found that there was minimal teaching of child psychiatry. Since competency is most strongly related to residency and not to post-residency experience,⁸ it is logical to assume that a significant number of FPs do not feel adequately equipped to detect and manage common child psychiatry problems. A working group from the departments of family medicine and psychiatry at the University of Western Ontario (UWO) and the University of Ottawa, and the Division of Child Psychiatry at UWO had several meetings, from which a focus group, representing rural FPs and including an educator from Hanover, Ont., was formed on Sept. 21, 1999. A questionnaire was developed to survey FPs practising in rural or underserved areas of Southwestern Ontario.

The goal of the survey was to determine access to child and adolescent psychiatry and evaluate physician interest in continuing medical education (CME) in child psychiatry. There were 3 study hypotheses: 1) FPs practising in rural and underserved areas would identify limited access to psychiatric services for children and adolescents; 2) most FPs practising in these areas would lack confidence in knowledge and skills in management of child and adolescent mental health problems; and 3) few of these FPs would be interested in training opportunities to further their expertise in the detection and management of child and adolescent mental health problems and psychiatric disorders.

Method

A cross-sectional cohort of FPs practising in rural and underserved areas of Southwestern Ontario were studied. "Rural" practice is defined as an area with a population of less than 10 000, and "underserved" is defined as an area in which there is 1 doctor to 1380 people. A list of FPs who were currently practising in rural and underserved communities of Southwestern Ontario was compiled using the FP Section of the 1999 Canadian Medical Directory. The survey was distributed in 2000. The 2 largest cities, London and Windsor, were not surveyed. A questionnaire, developed by some of

the investigators (M.M.S., S.F., N.S. and J.R.), was mailed to FPs on the abovementioned list with a stamped, return-address envelope and an expected turnaround time of 6 weeks (see [Appendix 1](#)). At 6 weeks a second identical questionnaire was sent to the physicians who had not responded. Questionnaire data were analysed using SPSS version 9.0.

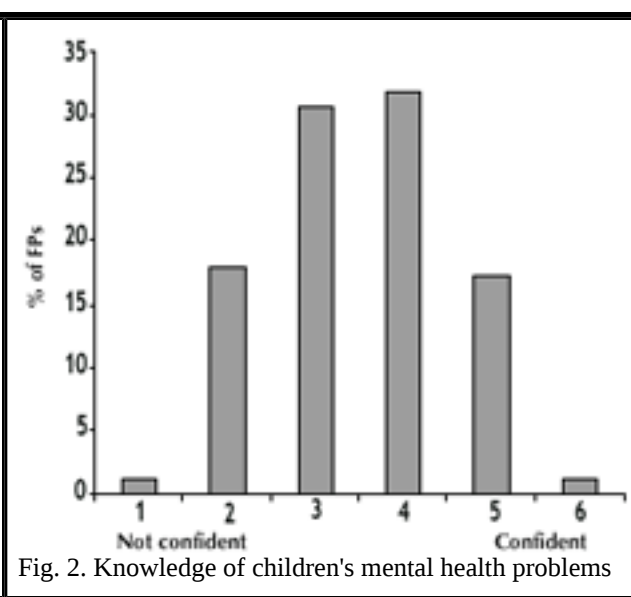
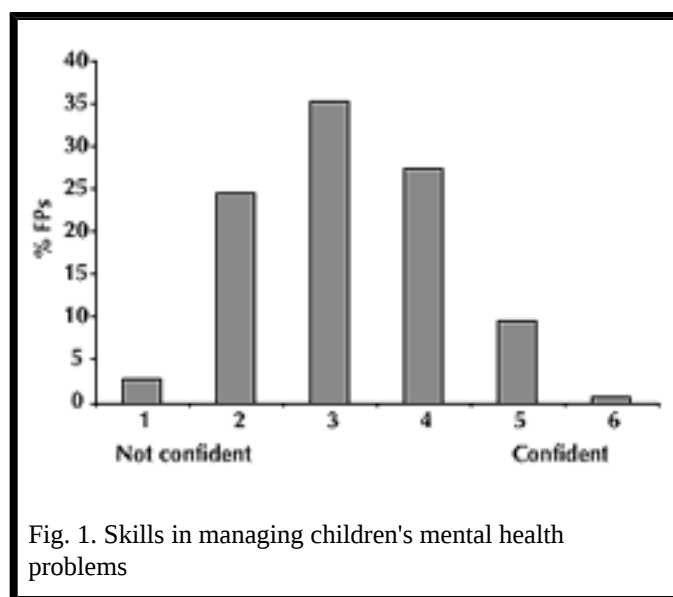
Results

Response rate and demographic data

A total of 242 completed questionnaires were returned, giving a response rate of 47.9% (242/505); 73.1% of respondents were male. This compares closely with the distribution of FPs in Ontario (male 71%, female 29%). 55.4% of respondents were in rural practice, with the remainder being in underserved areas. At the time of the survey, almost 51% of the respondents were between the ages of 36 and 50, and 46% had been in practice for more than 20 years, with the majority (87.4%) being in full-time practice. More than 50% of the FPs were certified with the College of Family Physicians of Canada (CFPC) ([Table 1](#)). Comparison of responders and non-responders showed statistically significant differences for gender and number of years in practice: more female FPs and physicians who had been in practice for 10 years or less responded ([Table 2](#)). Therefore, the sample in this study cannot be generalized to the whole population of rural FPs. For 43%, less than 10% of their practice involved psychiatry services, 44% said 10% to 20% did and 13% indicated more than 20% of their practices involved psychiatric services. 82.6% of respondents had no training and 17.4% had some training in child psychiatry. Respondents did not have an accurate concept of a children's mental health centre and they did not know when child psychiatrists actually visited their areas. Almost 80% felt there was a need for child psychiatry consultation visits to their community, and 65% of the respondents felt there is a need for an expert FP to do child psychiatry visits.

Respondents' confidence in their knowledge and skills in children's mental health

Confidence was defined as a score of 5 or more on a 7-point Likert scale. 10.3% of the respondents scored 5 or more with respect to their confidence in their skills in managing children's mental health problems ([Fig. 1](#)). Slightly more FPs (18.1%) felt confident in their knowledge of children's mental health problems ([Fig. 2](#)). No statistical difference was found between male and female FPs and length of time in practice. Subgroup analysis indicated that confidence with knowledge and skills in managing children's mental health problems were not significantly different between male and female respondents and the number of years they had been in practice.



Need for mental health training

The majority (84.3%) of respondents felt they needed more training in child and adolescent psychiatry. For those who answered No, 75.7% gave no reason, 10.8% felt they had no time or were too busy, 2.7% were retired, 2.7% said they were too old, 5.4% did not see children and 2.7% were reducing their hours of practice. Of the respondents who wanted more training, the top 3 requests for additional training were CME in the community, small group teaching by a child

psychiatrist and self-instructional packages. Most of the physicians (83.9%) were not interested in extra funded training in child psychiatry. Analysis between male and female FPs and their interest in receiving training was not statistically significant. However, subgroup analysis of opportunities to have funded training in child psychiatry indicated that more male physicians who had been in practice for less than 10 years were, or possibly were, more interested in receiving funded training ($p < 0.035$). There was no statistical difference for female physicians.

The FPs were asked to rank 11 topics in child psychiatry in order of importance. Behaviour disorders and attention-deficit hyperactivity disorder (ADHD) were ranked the highest (Table 3).

Respondents were asked to compare multiple learning needs in other specialty areas. On a 10-point Likert scale, more than half of the responders rated their needs as 7 or greater for child and adolescent psychiatry (Fig. 3).

Discussion

This paper had 3 hypotheses: 1) FPs practising in rural and underserved areas would identify limited access to psychiatric services for children and adolescents; 2) most FPs practising in these areas would lack confidence in knowledge and skills in management of child and adolescent mental health problems; and 3) few of these FPs would be interested in training opportunities to further their expertise in the detection and management of child and adolescent mental health problems and psychiatric disorders.

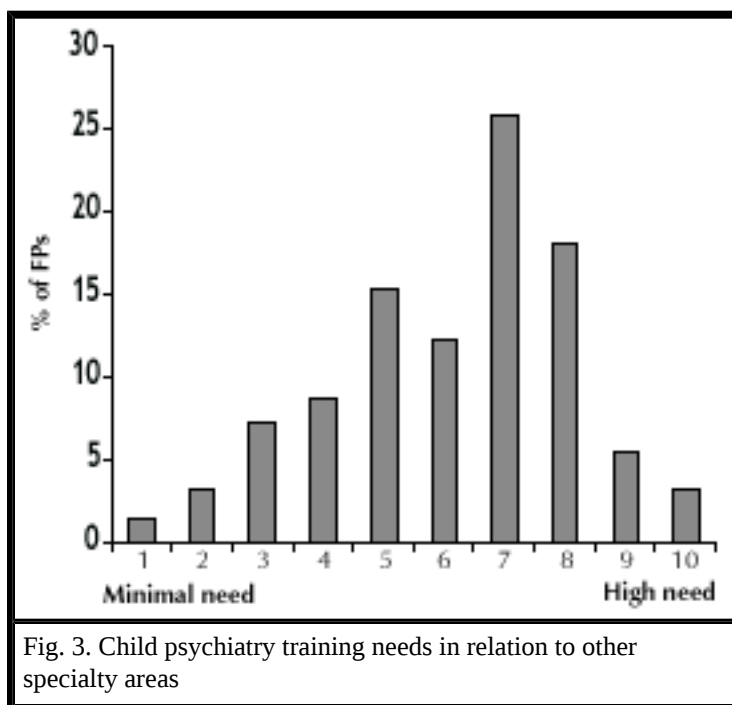


Fig. 3. Child psychiatry training needs in relation to other specialty areas

Eighty-seven percent of respondents spend less than 20% of their practice in the direct management of psychiatric problems in general, and 92% spend less than 10% of their time with child or adolescent mental health problems; 82.6% had no training at all in child psychiatry. Ninety percent have little confidence in their skills with respect to management of child psychiatric disorders, and 85% identified a need for more training in this area. It is important to note that the responders were more likely to be female and have been in practice for 10 years or less. One might speculate that the non-responders are not interested in children's mental health or, being more experienced, they do not feel the need for training.

With respect to its relative importance in their practice, 52.4% rated the need for training in child and adolescent mental health at 7 to 10 on a Likert scale of 10. This may represent feelings of inadequacy (i.e., the disproportionate fear of treating something for which one feels poorly trained). It may reflect the often stated assumption that the unmet needs in child and adolescent mental health are many, but rural physicians, given their time constraints, are unprepared to move into this area of medicine without adequate training or resources. It may reflect that psychiatric problems tend to present with increasing acuity and severity to the rural physician's office or emergency department¹⁰ and this results in a negative perception of child psychiatry practice.

There is a sense that rural physicians work in isolation. This survey identifies 80% who want regular visits from a child psychiatrist and 65% who want one of their physicians to be a local expert. Rural and remote physicians have reported that they have largely given up hope of help from psychiatrists. A series of focus groups held with FPs in 7 communities across Ontario consistently identified high levels of dissatisfaction with the accessibility of timely psychiatric consultation and treatment, poor communication on the part of mental health services, and cumbersome intake procedures of many mental health services. FPs frequently felt their judgement was undervalued by psychiatrists. FPs may have a different approach to diagnosis and treatment than the mental health care delivery service due to the realities of family medicine, the undifferentiated nature of presenting problems, the long-term physician-patient relationship, and the frequent overlap of physical and mental health problems. In the child and adolescent age group, FPs described common areas of concern such as behaviour problems, eating disorders, drug abuse and unplanned pregnancies.¹¹ Rural physicians are faced with significant child and adolescent mental health issues but perceive themselves to be poorly trained and unsupported.

And how do they see solutions? Restructuring has led to a shift in resources from hospitals to community services, with increased expectations for the levels of care to be delivered by FPs. Establishing and strengthening partnerships between

primary care and specialty providers is important to enhance the role of FPs as primary providers of mental health care and to increase their access to advice and treatment.¹² At Memorial University of Newfoundland, which has no formal mental health training with psychiatrists, a survey was sent to the graduates of the family practice residency program between 1990 and 1995. Respondents felt confident addressing most of the mental health needs of their patients. They did express a need for additional training in child and adolescent mental health — in particular, ADHD, learning disorders, adolescent suicide and child sexual abuse.¹³

In our study, the top 5 topics identified as problem areas were behaviour disorders, ADHD, problem adolescents, interviewing skills and mood disorders. Eighty-four percent of respondents were not interested in funded training programs in child and adolescent psychiatry. However, 8% were interested, which may be an adequate number if we compare, for example, training issues in rural obstetrics. With few doctors having special skills in cesarean sections, working within a supportive group of colleagues can have a significant impact in the whole area of rural obstetrics. Similarly, a small group of specially trained family doctors could have a significant impact on management of child and adolescent mental health in their region. This might easily be accomplished through the acquiring of skills in relatively few areas — ADHD, mood disorders and advice or support around behaviour disorders, problem adolescents and interviewing skills. How this training would take place presents special problems in rural communities. Specific, practical, and time-efficient training techniques need to be developed in order to have an enduring effect on the primary care physician's ability to recognize and manage psychiatric disorders. Training programs could be developed as highly structured standardized modules. These training modules should be based on problem-based learning techniques for teaching psychiatric differential diagnosis and treatment planning. Each module should contain standardized videotapes demonstrating interviewing techniques and psychiatric differential diagnosis and have adequate competency-based evaluation instruments for trainee assessment. Well defined learning objectives and outcome measures are essential for trainees and supervisors to assess the impact of the training strategies and document their efficacy.¹⁴

Few rural physicians are prepared to leave their usually underserved regions to pursue further training. Their training method of choice is to bring the experts to their own community for short stays. The Society of Rural Physicians of Canada initiated a program of bringing small group learning facilitated by experts into rural areas (Dr. Keith MacLellan, Shawville, Que.: personal communication, 2001). The CFPC is encouraging practice-based small-group learning as an excellent method for local CME (Dr. Keith MacLellan, Shawville, Que.; personal communication, 2001).

FPs cannot work in isolation in the area of children's mental health. It will be important for FPs to become part of multidisciplinary programs in their community. They could consult with the mental health professionals who would be providing assessment, intervention and case management for children, adolescents and their families. The establishment of mental health teams in collaboration with FPs would provide a more effective delivery care system for children with mental health needs and their families.

There are a number of training opportunities that could be developed to aid the rural and underserved FPs in the area of children's mental health. One possibility is to pair an FP with a child psychiatrist to plan CME in the rural community. The teaching could be a combination of didactic and direct case-based learning. The second option would be small group teaching of interested FPs by a child psychiatrist and an FP with an interest in this area. Self-instructional packages could be developed and provided at the training sessions. The third possibility is to develop a scholarship program for the FPs interested in pursuing more intensive training.

A potential limitation of this study was the less than 50% response rate and the over-representation of females and physicians with fewer years in practice in the sample. However, subgroup analysis showed that there was no significant difference between male and female respondents and the years they had been in practice for confidence with knowledge and skills in managing children's mental health problems. This implies that these results may be interpreted as valid for the whole population.

Conclusion

FPs in rural and underserved areas of Southwestern Ontario feel they need more access to child and adolescent mental health services. Most of the survey respondents have minimal training in child psychiatry and lack confidence in their knowledge and skills in managing children and adolescent mental health services. Despite small numbers of child psychiatry problems in their practices, the majority of FPs want more training. Pairing FPs with a child psychiatrist, in a small teaching group, and a scholarship program are all options for helping FPs gain the training they need.

Margaret M. Steele, Associate Professor, Division of Child Psychiatry Department of Psychiatry, University of Western Ontario, London, Ont.; Sandra Fisman, Professor, Division of Child Psychiatry Department of Psychiatry, University of Western Ontario, London, Ont.; Gordon Dickie, Associate Professor, Department of Family Medicine, University of Western Ontario, London, Ont.; Neal Stretch, Assistant Professor, Department of Family Medicine, University of Ottawa, Hanover, Ont.; James Rourke, Professor, Director of the Southwestern Ontario Regional Department of Family Medicine, University of Western Ontario, Goderich, Ont.; Anne Grindrod, Tech Dip; Research Assistant, Centre for Studies in Family Medicine, Department of Family Medicine, University of Western Ontario, London, Ont.

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Correspondence to: Dr. Margaret M. Steele, London Health Sciences Centre, Victoria Campus, 346 South St., Rm. 102D, London ON N6A 4G5

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