

Mental Health in Family Medicine



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Training teachers to teach mental health skills to staff in primary care settings in a vast, under-populated area

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Abstract

[Go to:](#)

Background The Arkhangelsk Oblast is an area the size of France with a sparsely distributed population. The existing primary care staff have had very little training in the management of mental health disorders, despite the frequency of these disorders in the population. They requested special teaching on depression, suicide, somatisation and alcohol problems.

Methods An educational intervention was developed in partnership with mental health and primary care staff in Russia, to develop mental health skills using established, evidence-based methods. After a preliminary demonstration of teaching methods to be employed, a 5-day full-time teaching course was offered to trainers of general practitioners and feldshers.

Results The findings are presented by providing details of improvements that occurred over a 3-month period in four areas, namely depression in primary care, somatic presentations of distress, dealing with suicidal patients, and alcohol problems. We present preliminary data on how the training has generalised since our visits to Archangelsk.

Conclusions Teachers who are used to teaching by didactic lectures can be taught the value of short introductory talks that invite discussion, and mental health skills can be taught using role play. The content of such training should be driven by perceived local needs, and developed in conjunction with local leaders and teachers within primary care services. Further research will be needed to establish the impact on clinical outcomes.

Keywords: education, family practice, mental health

Introduction

[Go to:](#)

Over the last 30 years, much of our research has focused on helping primary care doctors to communicate more effectively with people who have mental health problems. We knew that some doctors were more accurate than others in recognising depression, and that the better recognisers exhibited certain key behaviours, including making better eye contact with the patient, beginning with open questions and moving gradually to more closed-ended ones, and asking directive questions about key symptoms and problems later in the consultation.¹ We developed interactive training using video feedback and role-play methods to help doctors to acquire these and more specific skills related to the assessment and management of depression, with some success.² However, like others,³ we were unable to demonstrate an impact of such training on clinical outcomes for patients,⁴ and the systematic review of the field by Gilbody and his colleagues⁵ concludes, rather pessimistically, that 'commonly used guidelines and educational strategies are likely to be ineffective' (p. 3145), although another more recent review has suggested that training is effective if combined with implementation of additional guidelines for new-onset depression.⁶

However, most of this research has been conducted in parts of the world that have well-developed primary care

services staffed by professionals who are already quite skilled in recognising and managing mental health problems. In many other regions, staff in primary care have received very little previous training in mental health, and there is an urgent need to ensure that they can address the mental health problems within their communities.

Members of the Baltic Alliance from Norway who are engaged in a project to improve mental health services in Archangelsk (see [Figure 1](#)) were asked to assist in dealing with the problem of the Oblast having, as in some other parts of Russia, very high rates of suicide and alcohol-related problems.⁷⁻⁹ Meetings of senior staff from primary care services, psychiatric services, the Ministry of Healthcare and the local university were convened, resulting in two of the authors (DG and LG) being invited to visit Archangelsk to assist local colleagues in improving the mental health skills of staff in primary care. Our previous experience in the Sverdlosk Oblast in Siberia had been well received, and had resulted in large numbers of primary care staff being trained by one of our Russian colleagues (AZ).^{10,11} She agreed to participate in the course in order to demonstrate skills in Russian during the course.



[Figure 1](#)

Map showing location of Arkhangelsk Oblast in the Russian Federation.

A first visit to Archangelsk in June 2010 demonstrated our approach to teaching mental health skills to senior staff from primary care and general practitioners chosen for their interest in mental health. We demonstrated the skills that needed to be taught, and the interactive methods that are used to teach them.¹² This course was well received, and we were asked to return to Arkhangelsk in January 2011 to train future trainers from within primary care to disseminate these skills, supported by both the departments of primary care (NR) and psychiatry (EP).

The Oblast covers an area roughly the size of France with a population of only 1.23 million. In some areas, medical services are provided by feldshers, who have a shorter training than medical professionals and a restricted range of available interventions. Mental health skills are relatively neglected compared with skills for physical diagnosis, and our hosts asked us to focus on clinical skills related to alcohol dependence^{13,14} and suicide,^{15,16} in addition to depression³ and somatic manifestations of psychological distress.¹⁷

Method

Go to:

At the onset of our training course we tested both the factual knowledge and the clinical practices of the participants, and these were tested again at least 3 months after the participants had returned to work.

The course required the development of two skills which are little practised in Russia, namely the ability to give a short introductory lecture that leads directly into a discussion of relevant issues with the audience, and the ability to persuade staff to practise new skills in role play as a preparation for trying them out with their patients (see [Figure 2](#)). On our second visit we therefore opted for a 5-day full-time course in a rural location in order to achieve as much as we could in the limited time available to us. All of the potential participants, many of whom had travelled for several hours across the oblast to attend, were asked to prepare a 10-minute lecture about one of the four areas, and were given detailed practical advice about how to present such a lecture.



[Figure 2](#)

Slides providing instructions for role-play exercises.

After baseline measures had been taken, the first day consisted of a talk about how to give a lecture, followed by demonstrations by ourselves of the kind of introductory lectures that might open a 1-day course in one of the four areas. In the afternoon we demonstrated skills in using role play, and invited discussion of the kind of problems that the trainees anticipated. The next 3 days were spent listening to each trainee give their prepared lecture, with the afternoons spent doing role plays. On the last day we discussed how to evaluate their training, and had a discussion on the problem areas experienced by the various groups of workers in primary care. We ended with open discussion and feedback about how the trainees had experienced the course. We arranged for all of the participants to try to give a course of their own on one of the four areas, and one of the authors (EP) agreed to carry out a

follow-up meeting of all the potential trainers in early 2012.

Results

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Table 1 shows the results of the factual and clinical practices measures for all of the participants in both courses, after it had been established that there were no differences between the two courses.

The image shows a table with columns for 'Baseline' and '3 months later' for various measures. The measures include 'Factual knowledge' and 'Clinical practice'. The table shows a general increase in scores from baseline to 3 months later for both measures.

Table 1

Changes in factual knowledge and clinical practice, shown as comparisons between baseline scores and scores 3 months later*

With regard to the professional background of the participants, 18 (56%) were GPs, seven (22%) were feldshers, seven (22%) were practice nurses, and there were also four psychologists, and one teacher from the training college. The participants had on average 18.5 years of clinical experience (range 9–26 years), and there were no differences between the GPs and the other participants in this respect.

We were delighted by the high standards of the lectures that the participants had prepared, and we were especially impressed by those who had prepared their own slides, and used local examples and gave examples of Russian data to illustrate their talks. All of the participants experimented with role play, but it was possible that more practice was needed with this difficult and unfamiliar skill.

Follow-up data about teaching activities

There have been more than 36 seminars since our visit, with 70 GPs and 216 feldshers being taught about depression, 48 doctors and 118 feldshers being taught about suicide prevention, 6 doctors and 70 feldshers being taught about somatic presentations of psychological distress, and 33 feldshers (but no doctors) being taught about alcohol-related problems. Role play is the most difficult part of the seminars for our tutors, but some of them use it regularly. Those who avoid role play have been provided with additional training by the psychologists who attended the course. Every year there has been a conference open to primary care workers throughout the oblast, with the 2010 conference devoted to addressing the prevention of suicide, and the 2012 conference focusing on somatic presentations of distress.

Discussion

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We have shown that it is possible to achieve reasonable outcomes by providing an intensive 5-day training course for future trainers. It is necessary to move away from a model where teaching consists of didactic lectures without any discussion, to one that encourages maximal participation by the trainees, and practice of new clinical skills in a safe environment. Our first visit was undoubtedly necessary to convince our Russian hosts that we had something that would be useful for them, and their provision of suitable participants, and agreement that feldshers and primary care nurses should be included as well as GPs themselves, was an important factor in any success that has been achieved. We consider that provision of educational courses across this vast region will be essential both for increasing access to and improving outcomes for people with mental health problems.¹⁸

Our approach utilises many of the recommendations made by Hodges *et al*¹⁹ in their review of effective educational interventions. These include the importance of conducting a needs assessment of participants, involving leaders in primary care who can help to define competencies, ensuring that psychiatrists engaged in education in primary care familiarise themselves with the context of primary care (notably by working in a shared care setting), linking learning objectives to real clinical practice, interactive educational methods (including practice of new skills under observation), and the provision of ongoing programmes rather than single sessions.

However, we note the shortcomings in the evaluation of our intervention, which reports self-perceived educational benefits and change in behaviour rather than actual changes in clinical practice, which will be more difficult to assess in many settings, but may be achieved with parallel development of audit and research expertise. We are also aware that not all of the future trainers have provided follow-up data on their new teaching, and our measurement tools could be further improved if they are needed again in the future.

Conclusions

[Go to:](#)

Training teachers in primary care to deliver training in mental healthcare skills is essential if we are to improve both access to care and the quality of care for people with mental health problems. Teachers who are used to teaching by delivering didactic lectures can be taught the value of short introductory talks that invite discussion, and mental health skills can be taught using role play. The content of such training should be driven by perceived local needs and developed in conjunction with local leaders and teachers within primary care services. Further research will be needed to establish the actual impact on clinical outcomes.

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[Go to:](#)

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