Family medicine residents' perspective on ability to manage common psychiatric disorders

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Introduction

- Family medicine physician are the front-line clinicians that provide psychiatric care for depression, anxiety, PTSD, bipolar disorder, and schizophrenia
- Outside of the dedicated one-month behavioral health rotation, there is limited collaboration or training with behavioral health care providers
- Studies have shown that family medicine residents do not feel competent managing common psychiatric disorders and expressed the need for more education and training especially on psychopharmacology [1, 2, 3]
- A study done at the University of Florida, suggests that a collaborative care model of training can be more beneficial [6]
- A review of different conceptual models (Training, consultation-liaison, collaborative care, replacement/referral) shows the most effective model is collaborative care, but it is less feasible especially in rural areas [7,8]
- A randomized trial done at VA outpatient clinics showed that the collaborative care model can be adapted successfully for primary care clinics without outside psychiatrists using telehealth [9]

Objective

- Evaluate Family medicine (FM) resident's perspective on their ability to diagnose and manage common psychiatric disorders seen in primary care
- Use data to further improve psychiatric training in FM residency

Methods

- Survey sent to 30 FM residents that had done one-month BH rotation in the last 12 months

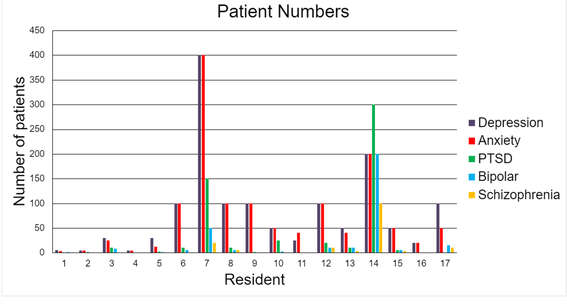
Sample Survey Questions

- How would you rate your ability to diagnose (depression/anxiety/PTSD/bipolar/schizophrenia) for patients in your practice?
- How would you rate your ability to provide 1st line ___ treatment for patients in your practice?
- How would you rate your ability to adjust medications for ___ treatment if the 1st line treatment is ineffective or intolerable?
- Response based on Likert scale 1-5 (1=poor, 2=fair, 3=good, 4=very good, 5=excellent)
- Additional question asked the number of patients with specific mental health diagnoses they have treated, perceived helpfulness of and experience with a collaborative care model, and use of the PHQ-9
- Analysis of responses with ranges, mode, media

Results

- 57% survey response
- 53% HO3s, 29% HO2s, 18% HO1s
- Similar percentage from each clinic site (DOC, BMC, Offutt, none from OW)
- Mean of 4.66 of residents would find the collaborative care model helpful to co-manage mental illness
- Residents very often used PHQ9 to manage depression

Graph 1: Number of patients treated by residents with the common psychiatric disorders.



Results

Table 1: Mean response for the ability/confidence level of residents in diagnosing, starting first-line treatment, and adjusting treatment of common psychiatric disorders.

	Meant resident self-related ability to perform the following action:		
	Diagnose	Start 1st line Treatment	Adjust Treatment
Depression	4.00	3.94	3.76
Anxiety	3.94	3.76	3.59
PTSD	3.11	2.82	2.12
Bipolar	2.76	2.06	1.76
Schizophrenia	2.35	1.82	1.47

Conclusion and Future Directions

- Most residents feel they can diagnose and manage depression and anxiety
- Most residents don't feel confident to diagnose and treat PTSD, bipolar, and schizophrenia
- 53% of the residents were close independent practice and would have no further formal training in psychiatry
- Only 3 residents had at least another month of BH during residency
- This study will serve to evaluate the need for more psychiatric training and provide a way for improvement by collaborating with diverse behavioral health providers and create an integrated program for the benefit of both resident training and patient care

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