Improving Our Care of Patients with Depression and Anxiety

Kyoto, May 15-16, 2019

Objectives

- This initiative's ultimate goal is to improve the care of patients with depression and anxiety by expanding the competence and confidence of family physicians to:
  - Assess and manage depression and anxiety
  - Employ shared decision making with patients

Our work today includes clinical education, patient communication and presentation skills topics.

Adult learning principles

Adults learn best when they can use their own life experience.

- Adults need to feel valued and respected – they come with their own vast experiences, ideas and perspectives – all of which must be brought into the training.
- Adults learn better when they actively engage and experience the concepts being taught.
- Adults learn best when the learning is reinforced, through various learning activities and relates to their everyday lives.

Mental health in context

The clinical issues facing family doctors

Prediction for the leading causes of disability and mortality in 2030

World
1. HIV/AIDS
2. Unipolar depressive disorder
3. Ischemic heart disease

High-income countries
1. Unipolar depressive disorder
2. Ischemic heart disease
3. Alzheimer's disease

Middle-income countries
1. HIV/AIDS
2. Unipolar depressive disorder
3. Cardiovascular disease

Low-income countries
1. HIV/AIDS
2. Perinatal disorders
3. Unipolar depressive disorder

Mathers & Loncar 2006 PloS One

Treatment gaps in depression

Country income level	Current coverage	Target coverage
Low income	7 percent	32 percent
Lower middle income	14 percent	44 percent
Higher middle class	21 percent	49 percent
High income	28 percent	56 percent

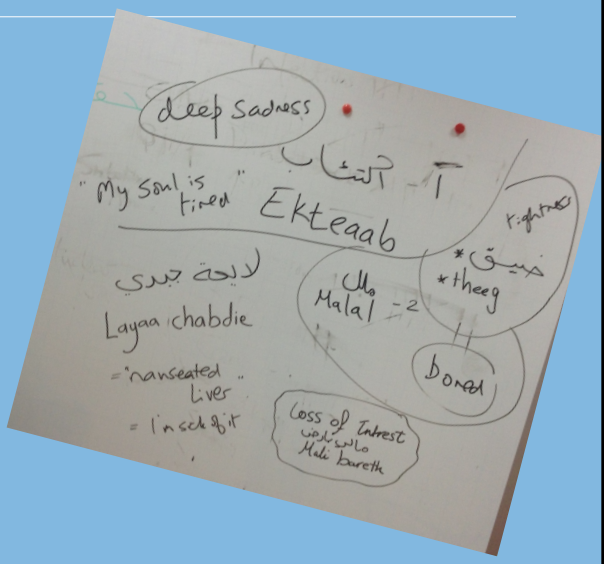
Stigma

- Significant problem
  - Non-disclosure, non-adherence, social isolation
- Worse if condition due to factors seen as controllable
  - e.g. mental health
- Perceived/felt stigma
  - Anticipated negative views of others
- Personal stigma
  - Stigmatising views held by self

Cultural perspectives

- Concepts of mental health
  - Idioms of distress
  - Causes of mental distress

What are the main perspectives in your culture?



Core Competencies

- Values
- Communications skills
- Assessment
- Management
- Collaboration and referral
- Reflective practice

Values

Family doctors consider mental health problems as important.

- Family doctors treat mental and physical health as of equal importance.
- Family doctors treat patients with mental health problems with dignity and respect.
- Family doctors take responsibility for diagnosing and managing patients with mental health problems, and support their families.

Communication skills

Family doctors adopt person-centered approaches to assess, manage and support people with mental health problems.

- Non-judgmental
- Symptoms, ideas, concerns, expectations
- Empathy and compassion
- Shared decision-making
- Culturally-appropriate care

Emphasis on dialogue

- ✓ Showing empathy
- ✓ Adjusting information to patient's context
- ✓ Framing in a positive way
- ✓ Involvement in decisions on management
- ✓ Empowering

Core skills

- Attentive body language
  - Facial expressions, eye contact, gestures to show engagement and interest
- Following skills
  - Open-ended questions to facilitate the patient in telling their story, with attentive silences
- Reflecting skills
  - Paraphrasing, summarizing or repeating back what has been said to clarify and show understanding, reflect back feelings

Assessment

Family doctors identify and diagnose common mental health problems, and can identify severe mental health problems and assess risk.

- Assess psychological stressors and supports
- Assess impact on function
- Aware of cultural diversity

BATHE technique

Background	What's going on in your life? Tell me what has been happening?
Affect	How does that make you feel? How has that affected you?
Trouble	What troubles you about this? What bothers you the most about this situation?
Handling	How are you handling that How have you been managing this program?
Empathy Instill hope by expressing your understanding of what the patient is going through …	I imagine that could be /may be difficult/ You seem to be going through a lot.

Cultural awareness tool

- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think illness does to you?
- What are the chief problems it has caused for you?
- How severe is your illness?
- What do you most fear about it?
- What kind of treatment/help do you think you should receive?
- Within your own culture how would your illness be treated?
- How is your community helping you?
- What have you been doing so far?
- What are the most important results you hope to get from treatment?

Management

Family doctors manage people with common mental health problems, and the physical health of people with severe mental health problems.

- Psychosocial interventions
- Pharmacological interventions
- Engage with patients and caregivers

Collaboration and referral

Family doctors use a range of available options and resources for care of people with mental health problems, and tailor them to patients' and caregivers' needs.

- Patient, family and social networks
- Primary care team
- Specialist care

Reflective practice

Family doctors take care of their own health and well-being.

- Aware of their own limits
- Seek support from others
- Nurture their own health

How do you take care of your own health and well-being?

Assessment of depression and anxiety

Assessing two common conditions we encounter in primary care

Assessing depression

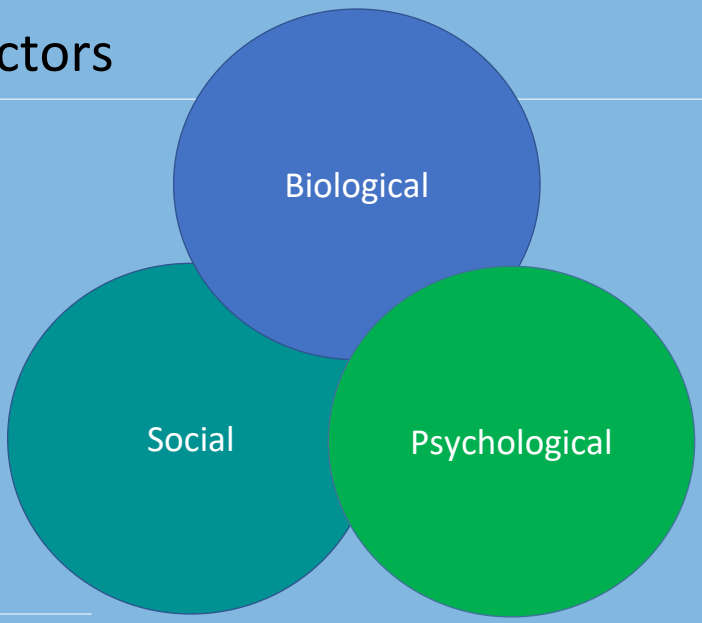
Depression is common!

- 10-20 percent of primary care attenders
- More likely, if:
  - Past or family history
  - Chronic physical illness
  - Life difficulties
  - Recent life stresses

Common presentations of depression

- Multiple persistent physical symptoms with no clear cause
- Low energy
- Fatigue
- Sleep problems (sleeping too much or too little)
- Anxiety
- Significant change in appetite or weight (weight gain or loss)
- Beliefs of worthless ness
- Excessive guilt
- Indecisiveness
- Restlessness/agitation
- Hopelessness
- Suicidal thoughts and acts

Contributing factors



Identifying depression

The length of time that a person experiences the symptoms is one of the distinctions between depression and general low mood.

How long do you think symptoms should be present?

Mood

During the past 2 weeks have you …

Been feeling down, depressed or hopeless?

Been bothered by having little interest or pleasure in doing things?

If YES to either question

- Assess the full range of depressive symptom and the level of functional impairment

Assessment

Does the person have depression?

- Has the person had at least one or the following core symptoms of depression for at least TWO weeks?
  - Persistent depressive mood (are they sad?)
  - Markedly diminished interest in or pleasure from activities?

If YES …

Has the person had several of these symptoms for at least TWO weeks?

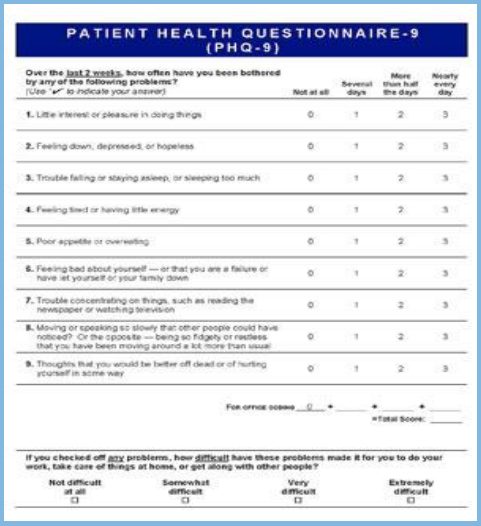
- Disturbed sleep or sleeping too much
- Significant change in appetite or weight
- Beliefs of worthlessness or excessive guilt
- Fatigue or loss of energy
- Reduced concentration?
- Indecisiveness
- Observable agitation or physical restlessness
- Talking or moving more slowly than usual
- Hopelessness
- Suicidal thoughts or acts

Does the person have considerable difficultly with daily functioning in personal, family, social educational, occupational or other areas?

Diagnostic aids may help

- PHQ-9
- BDI
- HAD

Remember: These are aids, NOT substitutes for careful, patient-centered clinical assessment



PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✔" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: 0 + ____ + ____ + ____ = Total Score: ____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

ICD-10 depressive episode

Low mood

Loss of interest

Reduced energy

+

Plus 2 of these:

- Loss of self-esteem
- Guilt
- Suicidal thoughts
- Reduced concentration
- Agitation or retardation
- Sleep disturbance
- Appetite disturbance

DMS-5 major depression

Low mood *or* Loss of interest or pleasure, for at least two weeks

Plus 4 of these:

- Change in sleep pattern
- Change in appetite or weight
- Poor energy, tiredness
- Poor concentration, forgetfulness
- Guilt, worthlessness
- Agitation, retardation
- Suicidal ideas

Severity

- Mild
  - ICD 2+2; DSM 1+4
  - Normal function possible, with effort
- Moderate
  - ICD 3+>2; DSM 2+>4
  - Normal function affected
- Severe
  - Most/all symptoms
  - Minimal function

Trajectory

- Most cases of mild depression do not increase in severity
- Cases of moderate and severe depression are more likely to be associated with disadvantage, abuse, morbidity and disability

Gunn J et al, J Affect Disord 2013

Differential diagnoses

- Anaemia
- Malnutrition
- Hypothyroidism
- Bipolar disorder
- Grief and mourning

Physical conditions that resemble depression

Condition	Symptoms
Anaemia	Tiredness, loss of energy, problems sleeping, physical aches and pains, problems concentrating
Malnutrition	Tiredness, loss of energy, loss of appetite, lack of interest in food and drinks, poor concentration, low mood, feeling weak
Hypothyroidism	Tiredness, muscle aches and feeling weak, changes in appetite (weight gain), low mood, problems with memory and concentration (slowed thinking), loss of libido, loss of energy

Mania

An acute episode with symptoms that last for at least ONE week:

- Extreme moods
- Lack of sleep
- Excessive energy, activity and talking
- Recklessness and risk taking behaviour

Grief

- Normal reactions to loss
- Local perspectives
  - How do people grieve in your community?

At what point in the grieving process would you suspect that your patient is no longer grieving, but showing signs of depression?

Risk

You must ask yourself, is your patient in risk of:

- Harm to self
- Harm to other
- Harm from others
- Self-neglect

Suicide risk

Talking about self harm/suicide is essential, but it does NOT increase the risk.

- Intent
- Plans
- Action
- Prevention

Assessing anxiety

Anxiety is very common!

- Global lifetime prevalence = 31 percent
- Most common mental health condition in primary care, with about 20 percent of all consultations
  - Women > men
  - Young > old

Presentations

- Fatigue, insomnia, chronic pain
- Frequent attendance with multiple symptoms
- Organ system symptoms

Mood

During the past 2 weeks have you …

Felt nervous, anxious or on edge?

Been unable to stop or control worrying?

If YES to either question

- Assess the full range of anxiety symptoms and the level of functional impairment

Anxiety disorders

- Generalised anxiety disorders
- Panic disorders
- Phobias, e.g., social
- Obsessive-compulsive disorders
- Post-traumatic stress disorder (PTSD)

Generalised anxiety disorder

- Tense and anxious most of the time
  - For SIX months
- Restless
- Tires easily
- Reduced concentration
- Irritability
- Muscle tension
- Insomnia
  - No specific triggers

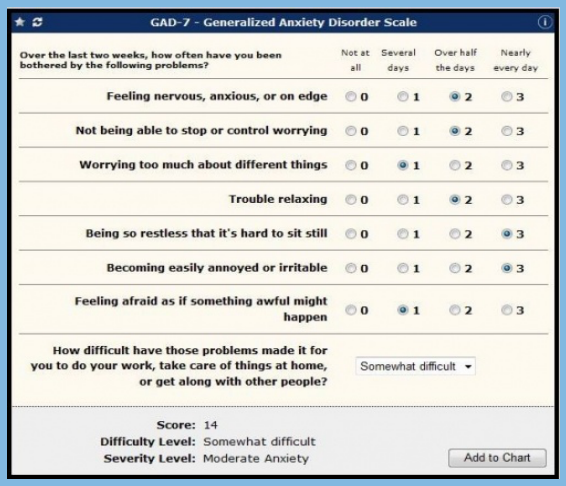
Panic attack/disorder

- Rush of fear
- Palpitations
- Shortness of breath
- Cognitive symptoms
  - E.g., “Am I dying?”
- Paralysis in feared situation
- Often specific triggers

PTSD symptoms

- Re-experiencing symptoms
  - Flashbacks, nightmares, intrusive thoughts
- Avoidance of reminders of trauma
- Hyperarousal
- Emotional numbing

Diagnostic aids may help



GAD-7 - Generalized Anxiety Disorder Scale

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it's hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

How difficult have those problems made it for you to do your work, take care of things at home, or get along with other people? Somewhat difficult

Score: 14
Difficulty Level: Somewhat difficult
Severity Level: Moderate Anxiety
Add to Chart

- GAD-7
- HAD
- PCL-5

Remember: These are aids, NOT substitutes for careful, patient-centered clinical assessment

Anxiety symptoms overlap with depression

- Mixed affective disorder
  - 50 percent of cases have co-existing anxiety and depression
- Symptom overlap
  - Fear, apprehension, chronic pain, GI symptoms, worry, agitation, difficulty concentrating, sleep disturbances, fatigue, low energy

Differential diagnoses

- Thyrotoxicosis
- Alcohol or drug withdrawal
- Hyperventilation
- Respiratory disorders
- Anaemia
- Hypoglycaemia
- Poor pain control
- Vestibular disorders
- Medication side effects

Your turn to practice

- Your patient is 27-years-old, presenting with complaints of fatigue, poor sleep and weight loss.
- How would you assess this patient for depression and anxiety?
- Are they at risk for self harm or suicide?

Providing feedback

DO	DO NOT
▪ Provide feedback shortly after observation of the role play ▪ Allow family doctor to reflect on their performance ▪ Give descriptive and specific feedback ▪ Focus feedback on what was done well ▪ Encourage family doctor to identify areas of improvement	▪ Focus on the person ▪ Use judgmental language ▪ Immediately list all the things that need improvement

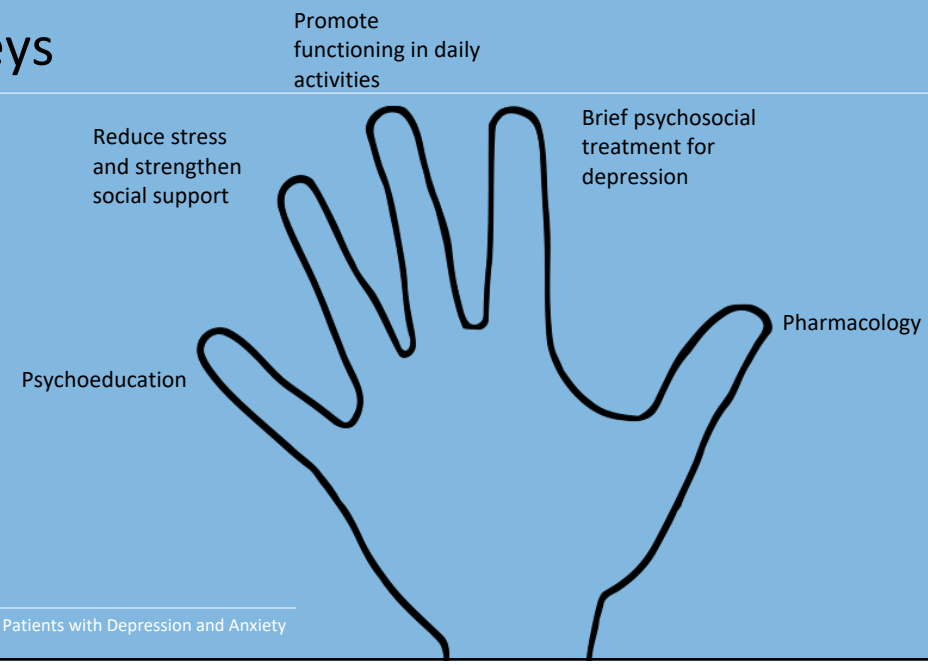
Managing depression and anxiety

Management and treatment options for your patient

Management options

- Self care
- Primary care interventions
  - Psychological
  - Pharmacological
- Other agencies
- Referring to specialists
- Patient perspectives

Five keys



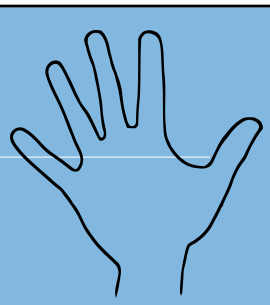
Improving Our Care of Patients with Depression and Anxiety

Treatment plans should include

- **Presenting problem**: **What** are the person's health and social needs?
  - **Which** interventions best meet the person's health and social needs?
- **Action plan**: Record the steps, goals and behaviours that need to happen, who will do them and when?
  - **Manage risks** (plans for what people can do in a crisis_
  - **Involve** the person and the caregivers to ensure ownership of the treatment plan

Improving Our Care of Patients with Depression and Anxiety

Psychoeducation



- Knowledge transfer
  - Causes of depression and anxiety
  - Education about treatments
- Promote understanding
  - What can make things worse or better
    - Including sleep hygiene
- Promote self-help

five ways to wellbeing

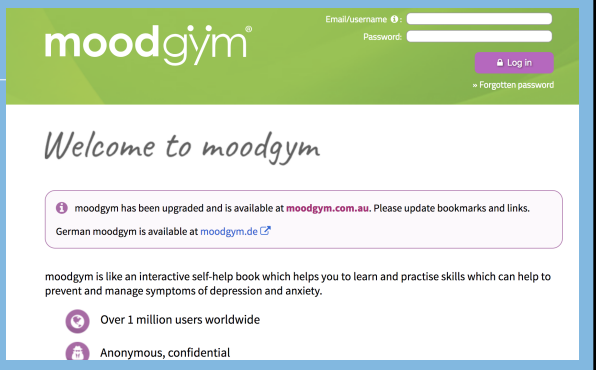
- Connect
- Be active
- Give
- Keep learning
- Take notice

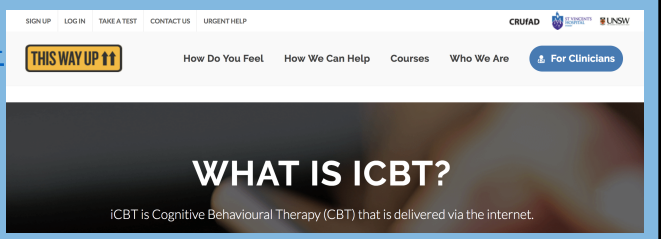
Self-help strategies

- Physical activity
- Social participation
- Lifelong learning
- Community resources
  - Options in your locality? Or community?

Guided self-help

- Facilitate support patients using guided internet-based therapies
- Examples of iCBT
  - Mood gym: https://moodgym.anu.edu.au/welcome
  - This way up: https://thiswayup.org.au/how-we-can-help/internet-delivered-cognitive-behaviour-therapy





Brief psychosocial interventions

- Stress management
- Behavioural activation
- Problem solving
- Interpersonal therapy
- Problem Management Plus (PM+)

Stress management

- Slow breathing exercises
- Progressive muscle relaxation
- Guided relaxation
  - Meditation
  - Mindfulness-based interventions

Behavioural Activation (BA)

- The goal of BA is to enable patients to regain functionality lost or reduced.
- BA includes activities to help patients:
  - Re-establish daily routines
  - Increase pleasurable activities
  - Address necessary issues such as unpaid bills

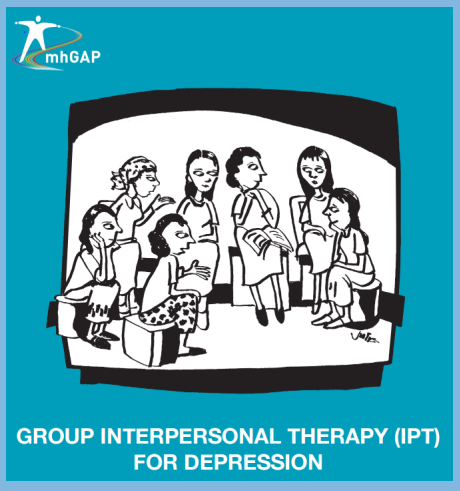
The Four BA Steps

1. Record in a diary what you are doing now
2. Make lists of routine, pleasurable and necessary things you would like to do
3. Order separate lists into one big list
   - Most difficult activities at the top
   - Easier activities at the bottom
   - Mix routine, pleasurable and necessary activities
4. Diary sheet to plan how to start doing these things

Problem-solving treatment

- Define the problem(s)
  - Prioritise problems
- Set specific achievable goals
- Brainstorm possible solution(s)
- Decide on solutions(s)
- Implement solution(s)
- Review progress

Interpersonal therapy



- Assumes that depression is triggered by interpersonal difficulties in one or more problem area:
  - Grief
  - Interpersonal disputes
  - Role transitions
  - Interpersonal deficits
- By understanding the relationship between interpersonal events and stress, and by helping the person improve his/her skills to handle these events, we can help the person recover

Your turn to practice

- Back to your 27-year-old patient, who has been depressed and anxious for more than two months. In addition to the symptoms of depression and anxiety, he is having problems with managing his life.
- How would you help this patient with solving basic problems, like:
  - Re-establishing daily routines
  - Increasing pleasurable activities
  - Addressing necessary issues such as unpaid bills

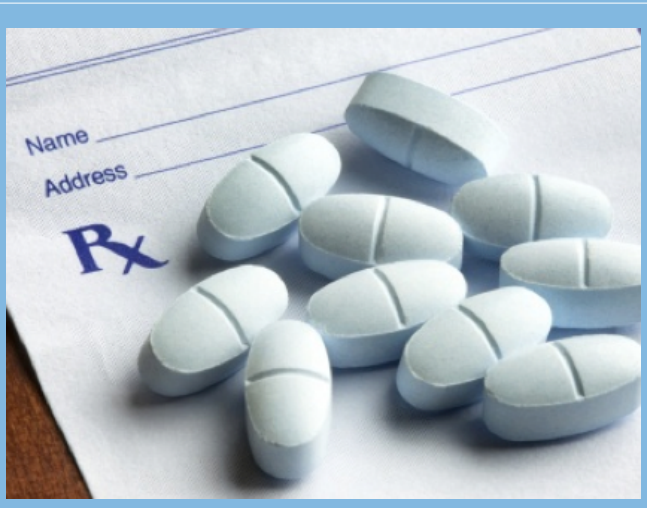
Multi-Component Behavioural Treatment (PM+)

- Problem solving counseling
- Managing stress (slow breathing)
- Behavioural activation
- Strengthening social supports

http://www.who.int/mental_health/emergencies/problem_management_plus/en/

Pharmacological interventions

- When to prescribe
- What to prescribe
- How to prescribe



Pharmacological interventions: When NOT to prescribe

DO NOT prescribe an antidepressant if/when …
The symptoms do not amount to depression (i.e., when the symptoms do not last two weeks and/or do not involve impaired functioning)
There is a recent history of bereavement or major loss
The depression is due to a physical cause
The person is pregnant/breastfeeding; as a first-line treatment offer psychosocial intervention
The child is younger than 12 years of age
Adolescents are 12-18 years of age; as a first-line treatment offer psychosocial intervention

- Usually, DO NOT prescribe medication at the first consultation – many patients' symptoms will improve after an empathetic consultation
- DO arrange follow-up appointment in one or two weeks to discuss treatment options

When to consider prescribing …

- Moderate to severe depression
- Mild to moderate depression with inadequate response to initial treatments
- Generalised anxiety disorder with inadequate response to initial treatments
- Persistent subthreshold depressive symptoms with functional impairment
- Patient preference

Which antidepressant?

Most Effective

Agomelatine
Amitriptyline
Escitalopram
Mirtazapine
Paroxetine
Venlafaxine
Vortioxetine

Most Acceptable

Agomelatine
Citalopram
Escitalopram
Fluoxetine
Sertraline
Vortioxetine

Cipriani et al, Lancet 2018

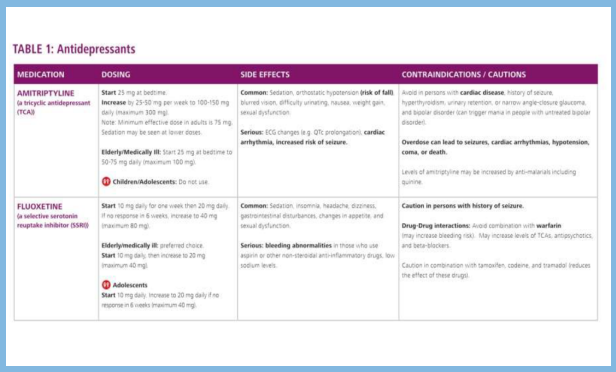


TABLE 1: Antidepressants

MEDICATION	DOSING	SIDE EFFECTS	CONTRAINDICATIONS / CAUTIONS
AMITRIPTYLINE (a tricyclic antidepressant (TCA))	**Start** 25 mg at bedtime. **Increase** by 25-50 mg per week to 100-150 mg daily (maximum 300 mg). Note: Minimum effective dose in adults is 75 mg. Sedation may be seen at lower doses. **Elderly/Medically Ill:** Start 25 mg at bedtime to 50-75 mg daily (maximum 100 mg). **Children/Adolescents:** Do not use.	**Common:** Sedation, orthostatic hypotension **(risk of fall)**, blurred vision, difficulty urinating, nausea, weight gain, sexual dysfunction. **Serious:** ECG changes (e.g. QTc prolongation), **cardiac arrhythmia, increased risk of seizure.**	Avoid in persons with **cardiac disease**, history of seizure, hyperthyroidism, urinary retention, or narrow angle-closure glaucoma, and bipolar disorder (can trigger mania in people with untreated bipolar disorder). **Overdose can lead to seizures, cardiac arrhythmias, hypotension, coma, or death.** Levels of amitriptyline may be increased by anti-malarials including quinine.
FLUOXETINE (a selective serotonin reuptake inhibitor (SSRI))	**Start** 10 mg daily for one week then 20 mg daily. If no response in 6 weeks, increase to 40 mg (maximum 80 mg). **Elderly/medically ill:** preferred choice. **Start** 10 mg daily, then increase to 20 mg (maximum 40 mg). **Adolescents** **Start** 10 mg daily. Increase to 20 mg daily if no response in 6 weeks (maximum 40 mg).	**Common:** Sedation, insomnia, headache, dizziness, gastrointestinal disturbances, changes in appetite, and sexual dysfunction. **Serious: bleeding abnormalities** in those who use aspirin or other non-steroidal anti-inflammatory drugs, low sodium levels.	**Caution in persons with history of seizure.** **Drug-Drug interactions:** Avoid combination with **warfarin** (may increase bleeding risk). May increase levels of TCAs, antipsychotics, and beta-blockers. Caution in combination with tamoxifen, codeine, and tramadol (reduces the effect of these drugs).

Precautions for Tricyclic antidepressants (TCAs)

Avoid use of TCAs in:

- The elderly, people with cardiovascular disease and people with dementia
- People with ideas, plans or previous acts of self-harm or suicide to minimise the risk of overdosing

Monitoring people on antidepressants

It is expected that people will have a positive response, but there are some results that will require action.

- If the person shows:
  - Symptoms of mania
  - Inadequate response
  - No response

What do you do when symptoms worsen or do not improve after 4-6 weeks?

Take THREE important steps before increasing the dose:

1. Ensure that the assessment is correct
2. Ensure that the person is taking the medication as prescribed
3. Ensure the dose is adequate

If there is no improvement after 4-6 weeks at maximum dose, consult a specialist.

When and how to stop an antidepressant

If after 9-12 months on therapy the person reports no or minimal symptoms:

- Discuss the plan with the person before reducing the dose
- Describe early symptoms of relapse
- Plan routine and emergency follow-up
- Reduce doses gradually over at least 4 weeks

Antidepressants: Summary

- Time for response to antidepressants is 4-6 weeks
- Treatment should continue for 9-12 months
- Taper slowly if ceasing medication
- Do not prescribe antidepressants to:
  - A functioning person
  - Someone recently bereaved
  - Children under 12 and pregnant/breastfeeding women
- Avoid TCAs if:
  - The person is elderly, has dementia or cardiovascular disease

Time to check our knowledge

Choosing an appropriate antidepressant

Which antidepressant would you recommend for adolescents age 12 and older?

Consider **fluoxetine** (but no other SSRIs or TCAs) only when symptoms present or worsen despite psychosocial interventions.

Which antidepressant would you recommend for children under the age of 12?

NO antidepressants should be prescribed. Use only psychosocial techniques.

Which antidepressant would you recommend for pregnant or breastfeeding women?

Avoid antidepressants if possible. Consider antidepressants at the lowest effective dose if there is not response to the psychosocial interventions. If the woman is breastfeeding, avoid fluoxetine. Consult a specialty, if available.

In which groups should you avoid and/or not prescribe Amitriptyline?

Avoid in elderly people. Do not prescribe it to people with cardiovascular disease. Like all antidepressants it should not be prescribed to children, and be avoided for pregnant women.

How should you prescribe Fluoxetine to someone who has an imminent risk of suicide?

If there is an imminent risk of self-harm or suicide, give only a limited supply of antidepressants (e.g., one week of supply at a time). Ask caregivers to monitor medicines and to follow-up frequently to prevent medication overdose.

Alternative approaches

- Herbal medicine
  - St John's Wort
    - 1050 mcg hypericin = 100 mg imipramine
    - Similar efficacy to sertraline, paroxetine
    - Not with SSRIs
    - With proper advice

- Mindfulness
  - Equivalent to antidepressants for recurrent depression

Mindfulness

- Based on meditation techniques
- **Being** fully present in the moment
  - Without judgment or evaluation
  - Without avoidance or trying to solve problems

Collaborative care

- Key ingredients
  - Systematic identification of patients
  - Case manager
  - Regular contact
  - Feedback to family doctors
  - Specialist intervention
- But often not available

Are there options for collaborative care in your community?

Follow-up

- Agree on plans for review with the patient
- Consider risk and severity
- Continuity of care is valuable
  - Proactive better than reactive
  - More frequent reviews at first
    - Until the condition has stabilised

Possible presentations at follow-up

At follow-up you may see people …

1. Improving: Actively engaging with management interventions and their symptoms are improving)
2. Remaining the same: Activity engaged in management interventions but their symptoms are remaining the same
3. Deteriorating: The symptoms are deteriorating and the person is feeling worse

Referring to specialists; refer when:

- Inadequate response to interventions
- Recurrent episodes
- History suggestive of psychotic disorder
- Persistent suicidal thoughts
- Self-neglect
- Patient or relative request referral
- Medical uncertainty or anxiety

Are there options for referral available in your community?

Shared decision-making

Care is best when patients and family doctors work together

Shared decision-making (SDM)

SDM is based on patient-centered communication and enables:

- More accurate diagnosis
- Better adherence to treatment
- Greater effectiveness
- Improved patient safety
- Fewer medico-legal issues
- Lower health care costs

RESEARCH

OPEN ACCESS

A three-talk model for shared decision making: multistage consultation process

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ABSTRACT

OBJECTIVES

To revise an existing three-talk model for learning how to achieve shared decision making, and to consult with relevant stakeholders to update and obtain wider engagement.

DESIGN

Multistage consultation process.

SETTING

Key informant group, communities of interest, and survey of clinical specialties.

PARTICIPANTS

19 key informants, 153 member responses from multiple communities of interest, and 316 responses to an online survey from medically qualified clinicians from six specialties.

guided by the experience and expertise of health professionals.

CONCLUSIONS

The revised three-talk model of shared decision making depicts conversational steps, initiated by providing support when introducing options, followed by strategies to compare and discuss trade-offs, before deliberation based on informed preferences.

Introduction

Shared decision making is a disruptive idea because it demands shifts in the power and control of interactions between clinicians and patients, and this is changing the way medicine is practiced. At the same time views vary widely as to what shared decision making is and how it can be done, which arises in part from the lack

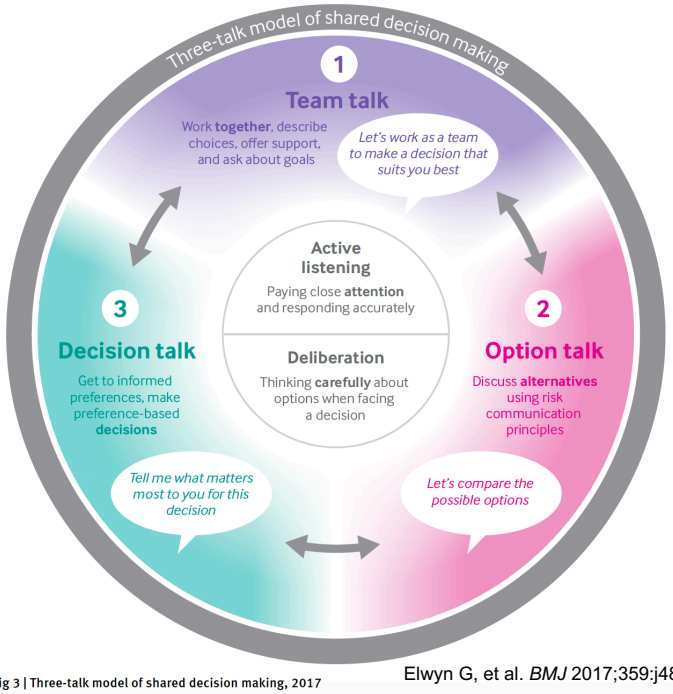

Fig 3 | Three-talk model of shared decision making, 2017

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Shared decision-making

If you are asked to make a choice, you may have lost of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.

Ask 3 Questions

To begin with, when asked to make a choice about your healthcare, it is best to try to make sure you get these answers to three key questions:

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make the right decision for me?

Your turn to practice

- Back to your 27-year-old patient, who has been depressed and anxious for more than two months.
  - In your initial assessment one week ago, you determined a low suicide risk.

- You consultation today is to discuss management options. How would you proceed?

Providing feedback

DO	DO NOT
▪ Provide feedback shortly after observation of the role play ▪ Allow family doctor to reflect on their performance ▪ Give descriptive and specific feedback ▪ Focus feedback on what was done well ▪ Encourage family doctor to identify areas of improvement	▪ Focus on the person ▪ Use judgmental language ▪ Immediately list all the things that need improvement

Customizing content

Time to talk about how you will teach this at home

Questions, interactivity and comments

- What worked well?
- Balance of attitudes, knowledge and skills?
- Was the information
  - Accurate?
    - Evidence-based? Biased?
  - Digestible?
    - Too complex? Too detailed?
    - Access to additional sources?
  - Relevant?
    - Culturally appropriate?

Presentation skills

Suggestions for an effective presentation

- Communicate in a language that is easy to understand (avoid jargon)
- Maintain eye contact with participants (but remember cultural issues)
- Speak loudly enough so those in the back can hear clearly
- Display enthusiasm for the topic and its importance
- Move around the room
- Use participants names as often as possible
- Display a positive sense of humour
- Be an effective role model

Components of a presentation

- Clear introduction
- Clear goals and objectives
- Content that is logical and facilitates learning
- Learner engagement, with space for questions, discussion, debate and reflection
- Learner inclusion making trainees ideas, experiences and knowledge to be part of the presentation
- Summary, and reflection on original goals and objectives
- Time for participants to reflect on the activity

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Reflective practice

Common problems

- Living with uncertainty
- Managing difficult patients
- Burn-out

How do you manage patients who are difficult?

five ways to wellbeing

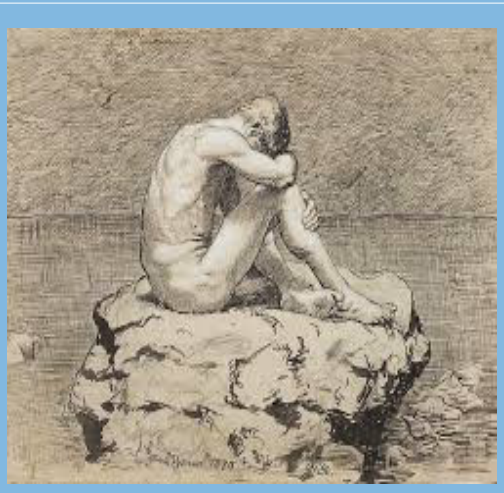
- Connect
- Be active
- Give
- Keep learning
- Take notice

Mindfulness

- Based on meditation techniques
- **Being** fully present in the moment
  - Without judgment or evaluation
  - Without avoidance or trying to solve problems

Turn toward suffering

- Seek to recognize it
- Be curious about patient's suffering
- Be present and engaged



Epstein & Back JAMA 2015

Finding joy

Where do you find the most joy in your life?

Gratitude diaries

Reduces stress and depressive symptoms among health care practitioners.

And with that, we thank you for your time and participation!

Cheng et al J Consult Clin Psychol 2015

Resources for this curriculum

WHO

mhGAP IG 2.0

http://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/

WONCA

Core competencies

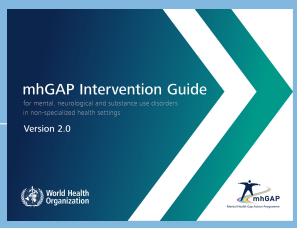
http://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/Groups/Mental%20Health/Core%20competencies%20January%202018.pdf

Non-drug interventions

https://www.wonca.net/site/DefaultSite/filesystem/documents/Groups/Mental%20Health/WPMH%20role%20of%20FPs%20in%20non%20drug%20interventions.pdf

First depression consultation

http://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/Groups/Mental%20Health/depression%20evidence%20based%20cons%20layout.pdf



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