

# Accessibility and e-learning models of mental health training for rural general practitioners

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## Background

Recent Royal Australian College of General Practitioners (RACGP) research showed a strong need for advanced mental health skills in rural communities.<sup>1</sup> Extensive analysis of these findings indicated that, despite high demand, mental health training in its current form has not met the upskilling needs of GPs working in rural and remote communities. Subsequent further analysis of available training highlighted that the rigid structure and workshop training formats made this training inaccessible to many rural and remote GPs.

Existing **Focused Psychological Strategies Skills Training** (FPS ST) options, in particular, require significant (and potentially costly) time away from community, and without more flexible training options many rural GPs are left without a viable avenue to gain advanced skills in GP mental health care. The training accessibility issue is demonstrated by the low numbers of uptake of FPS ST training by rural doctors shown by the number of Medicare Australia registration figures below.<sup>2</sup>

### Total GPs reported to Medicare as completed FPS ST by ASGC-RA (At 1 May 2016) – GPMHSC database

| RA Code                               | 1 Major City | 2 Inner Regional | 3 Outer Regional | 4 Remote | 5 Very Remote | Unknown/Overseas | Total  |
|---------------------------------------|--------------|------------------|------------------|----------|---------------|------------------|--------|
| Percentage                            | 71%          | 19%              | 8%               | 0.80%    | 0.40%         | 0.80%            | 100%   |
| ACRRM                                 | 12           | 20               | 14               | 2        | 1             | 1                | 50     |
| RACGP                                 | 814          | 201              | 79               | 7        | 4             | 8                | 1113   |
| Total                                 | 826          | 221              | 93               | 9        | 5             | 9                | 1163   |
| RACGP Rural FPS ST pilot participants | -            | 7                | 20               | 7        | 4             | -                | 38     |
| Percentage                            | -            | 18%              | 53%              | 18%      | 11%           | -                | 100%   |
| National GP headcount                 | 23,596       | 6,477            | 3,197            | 647      | 689           | -                | 34,606 |
| Percentage                            | 68%          | 19%              | 9%               | 2%       | 2%            | -                | 100%   |

Source: Australian Government Department of Health GP Workforce Statistics 2015-16

## Rationale

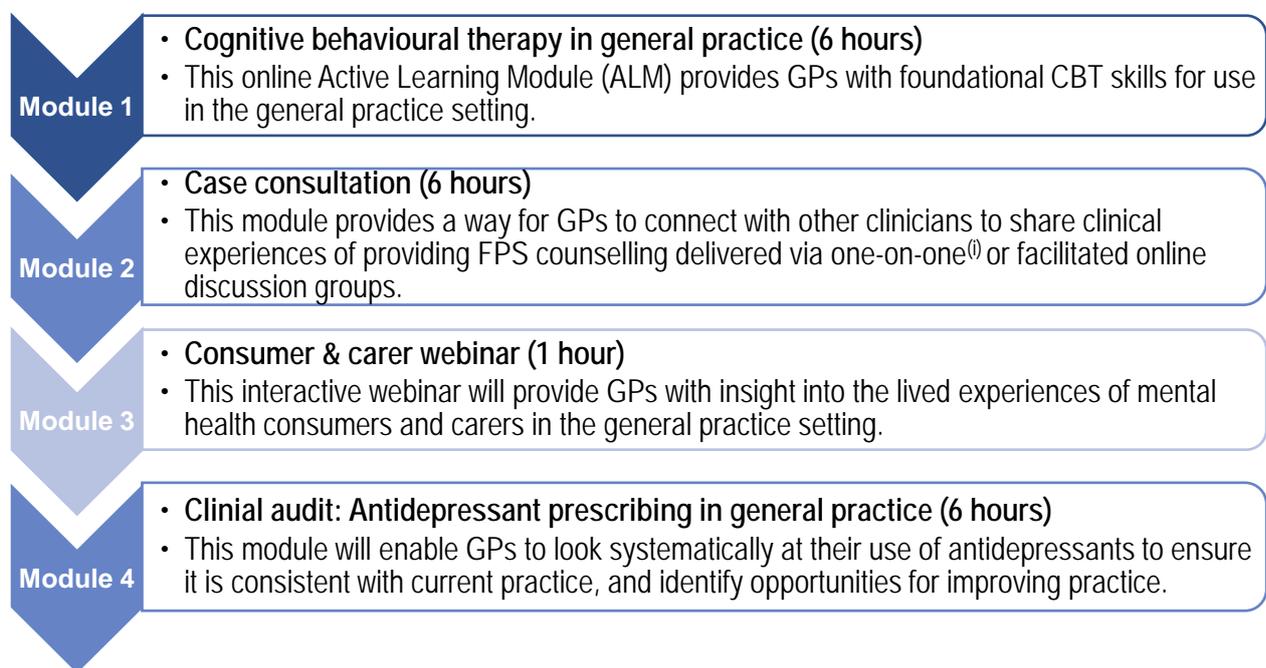
The low uptake of training by rural and remote GPs clearly demonstrated that more policy attention was needed to making skills training accessible to these doctors. A key requirement was to develop a training model which could support rural GPs to acquire these skills whilst remaining in their community. RACGP Rural chose to pursue a **blended e-learning model** featuring modular or staged progression through a clear training pathway.

## Introduction

Online learning may be of particular benefit for rural GPs to overcome access barriers and online learning methods have demonstrated improved efficiency and effectiveness of education delivery.<sup>3</sup> The RACGP Rural online FPS ST training model sought to address the critical gap in available regional, rural and remote mental health training opportunities. This flexible, innovative, modular approach combined technology, case-based discussion groups and locally available resources to provide GPs with the required levels of learning against the General Practice Mental Health Standards Collaboration (GPMHSC) requirements. The online package was designed to provide rural GPs with essential training in FPS ST to enable them to provide CBT-derived FPS counselling to patients.

The **case-based discussion** component was included to provide rural GPs with the opportunity to interact with their peers to discuss the practical application of their newly acquired skills. Providing interactive learning through this method gives the training flexibility to adapt to the needs of the learners and address any challenges that may arise, with expert facilitators guiding GPs as they get used to the “counselling relationship” necessary for effective CBT-derived FPS counselling. Small group learning has been shown to be an effective learning format for GPs<sup>4</sup>, however there is currently limited evidence for its effectiveness in an online format.

### RACGP Rural – FPS ST training modules



(i) Individual case based supervision was offered as an alternative in this program pilot, however uptake was low and logistical challenges significant. It's inclusion in future trainings is under review.

### Aim

This cohort study will review aspects of our modular online FPS ST training for rural GPs: firstly by identifying barriers and enablers to accessing mental health training and secondly by testing the accessibility and effectiveness of facilitated online case-based discussion groups for consolidating new learnings.

## Method

A pilot study was conducted with 38 rural GP training participants over the six-month period in which they undertook the RACGP Rural online FPS ST training package. Four online questionnaires measuring module effectiveness were incorporated, collecting a mix of qualitative and quantitative data against set training objectives. Each participant was emailed a link to a survey on completion of each module and a reminder email was sent the following week to improve response rate.

This data was collected to evaluate the modules both individually and as a complete e-learning package. Measures of training accessibility were designed to test barriers for rural training previously identified through policy surveys, including the key findings of earlier advanced skills research.<sup>1</sup>

The unique value of case-based discussion in enabling accessibility was specifically tested. Questions were designed to establish how module 2 delivered through a webinar platform could enhance the training through facilitating access and quality peer interaction lifting both time and access constraints. After module 1, the level of satisfaction was 75% (i.e. module 1 was ranked on average 3.75 over 5). After module 2, the level of satisfaction increased to 84.23% (i.e. module 2 was ranked on average 4.21 over 5). This corresponds to a 9.23% improvement in outcomes post module 2 (95%CI: 2.45-16.01%).

## Results

For the purposes of this study (identifying barriers and enablers to training access and testing the effectiveness of online case-based discussion group learning), the results from surveys at the conclusion of module 1 and 2 are analysed.

### Demographics

There were a total of 38 participants in the FPS ST pilot; 30 practising rural GPs and 8 registrars. Participants were located in RA2-5 and across the states, providing national coverage. The majority of participants were 44 years old or less (71%) with a predominance of early to mid-career GPs. The ASGC-RA distribution of participants showed most respondents were working in outer regional (53%), with a significant number working in Remote (18%), Inner Regional areas (18%) and Very Remote (11%) areas.

|          | Enrolled in module | Completed module | Completed survey | Response rate |
|----------|--------------------|------------------|------------------|---------------|
| Module 1 | 38                 | 36               | 31               | 86%           |
| Module 2 | 36                 | 31               | 26               | 84%           |

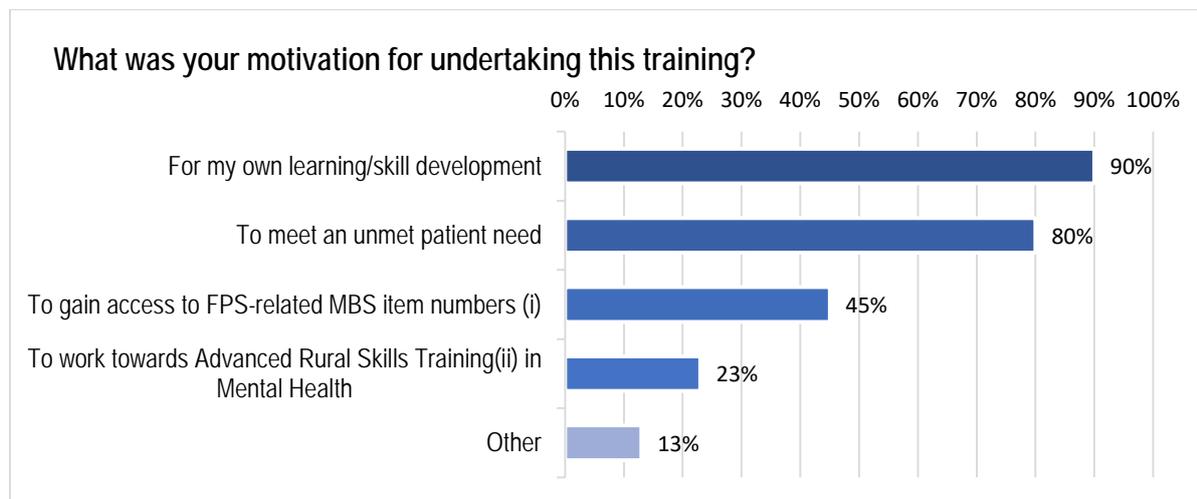
### Topic 1—Mental Health Training Accessibility

#### 1.1 Intent and motivation to undertake mental health training

Rural GPs' interest in undertaking further mental health skills training was explored by asking about duration of interest and motivations. Almost a quarter of survey respondents reported having considered completing FPS ST for 2 years or more and a further 16% had been interested for 1-2 years. Almost half (46%) of the participants had experienced difficulty in accessing FPS ST training and of those most (67.7%) reported that training was over 60kms away. There is a clear gap between interest in training and availability of training for rural GPs.

The majority of respondents stated that the training was for their learning and **skill development** (90%) and more than three quarters of training participants (80%) reported that they were undertaking

the training to **meet an unmet need** in their community. Some participants expressed a desire to formalise existing skills and gain more structure for using them in mental health consultations. Access to FPS related **MBS item numbers** was a key motivating factor for just under a half of participants (45%).

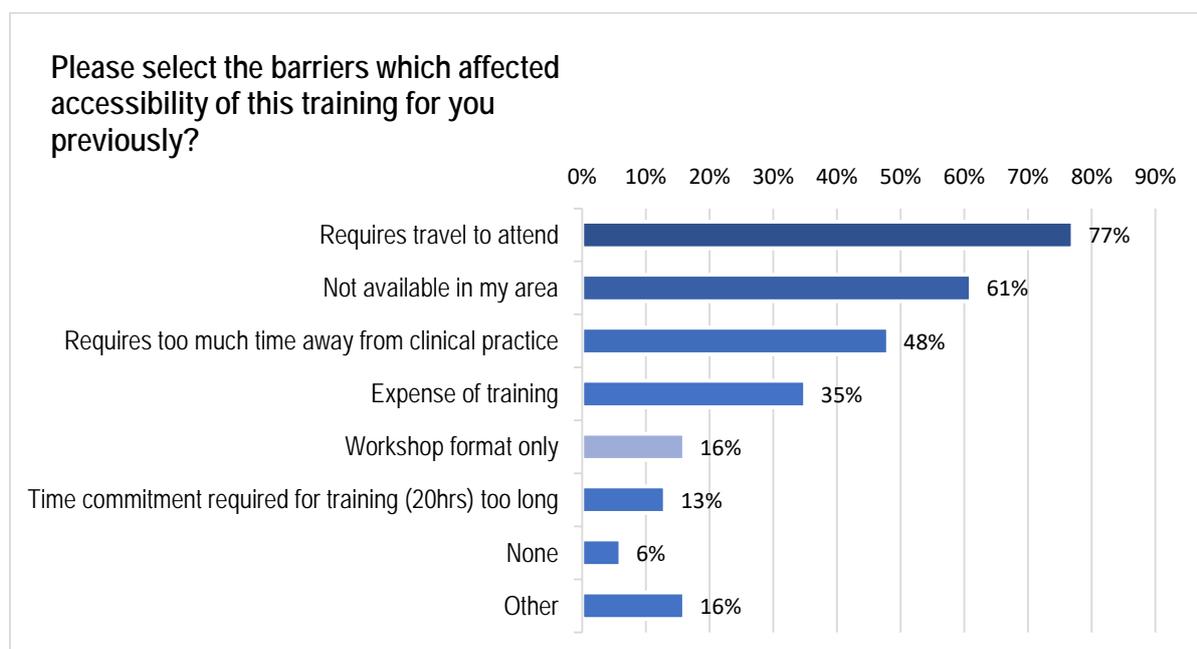


(i) The training has GPMHSC accreditation and on completion GPs can gain FPS provider registration with Medicare to access FPS related MBS numbers 2721, 2723, 2725 and 2727, enabling them to deliver FPS counselling in their practices.

(ii) Advanced Rural Skills Training (ARST) is the mechanism by which rural GPs may extend their expertise in a particular area and enhance their capacity to provide secondary-level care in their community. These skills encompass knowledge as well as physical and practical capabilities, undertaken in both procedural and non-procedural skill areas.<sup>1</sup>

### 1.2 Barriers to accessing training

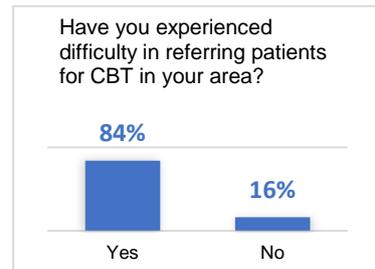
**Distance** was the most common barrier impeding rural GPs access to mental health training. Rural GPs most commonly cited no local availability of training (61%) and requiring travel to attend training (77%) as being the biggest barriers. 48% also reported that the time commitment required by the training was too much time away from clinical practice.



## Topic 2—Accessibility of Local Mental Health Services

### 2.1 Referral constraints

Participants were asked about barriers to referring patients from their community for CBT. Of the 31 rural GP pilot cohort sample 84% reported experiencing difficulties while 16% did not report any referral issues. For those reporting referral difficulties, a variety of issues were experienced, the most common being **long waitlists** for local services (61%).



The difficulty referring for CBT highlights the need for rural GPs to have access to opportunities to acquire and update skillsets in order to respond to unmet need in their community. GPs working in rural areas often have the most difficulty accessing training opportunities given their location. The training package through its accessible design sought to overcome this barrier.

## Topic 3—User acceptability: skills and knowledge acquisition

### 3.1 Effectiveness of e-learning approach

To track perceived changes in participants' knowledge and confidence in delivering CBT-derived FPS throughout the packaged training experience, a repeated-measures question was incorporated in the survey design to assess pre- and post-course confidence of the pilot cohort at module 1 and 2 endpoints.

Participants' confidence and perceived knowledge levels are an important part of learning and skill development as learned skills also require belief around personal efficacy for knowledge to be applied competently.<sup>5</sup> However, for the purposes of this research the measure was used to gauge user acceptability and effectiveness of the mode of training delivery only, not doctor competence. It is acknowledged that confidence does not necessarily equate to competence and that actual practice and skills competence would need to be expertly assessed post training. Nonetheless, participant self-assessment was considered important as a measure of user acceptability.

Prior to training a significant proportion of pilot participants indicated little to no capacity to deliver CBT prior to undertaking the training (module 1) with 45% and 36%, respectively, showed that they disagreed or strongly disagreed with the statement.

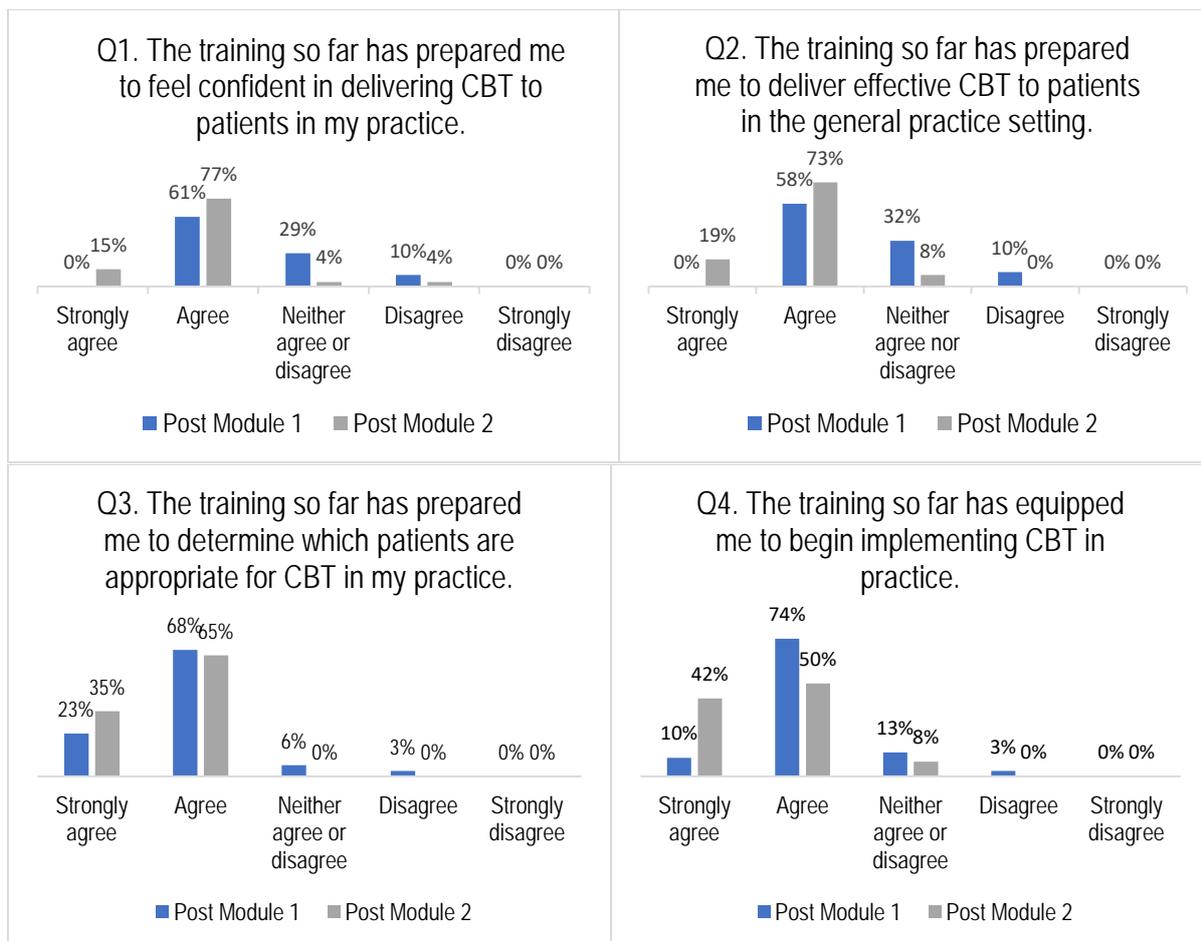


### 3.2 Comparative analysis of participant self-assessment (modules 1 and 2)

Repeated-measures questions were used to measure changes in participants' **perceived knowledge and confidence** in delivering CBT-derived FPS, self-assessed at the completion of module 1 and again at the completion of module 2, the case-based discussion component.

### Self-reported confidence

Questions were included to measure whether participants felt better equipped and more confident to deliver CBT-derived psychotherapy in their practice, after each of modules 1 and 2. Overall, there was a positive shift in response to all four questions post module 2 as shown in the graphs below.

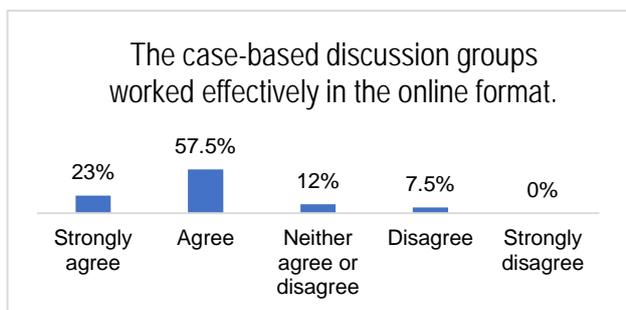


### Topic 4—Rurality and e-learning

#### 4.1 Technology and training

Evaluation of the effectiveness of module 2 online case-based discussion sought to test the efficacy of the use of a different e-learning approach in consolidating learnings to date. Aspects of the experience itself, and the ability of this format to meet learning outcomes were studied.

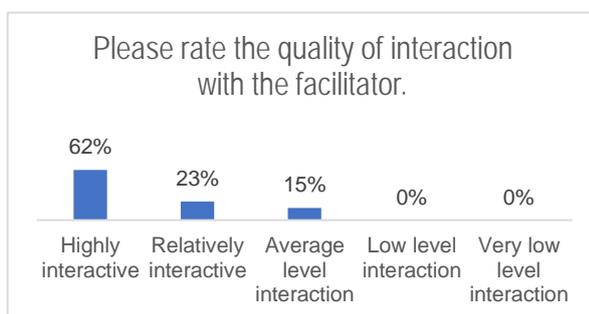
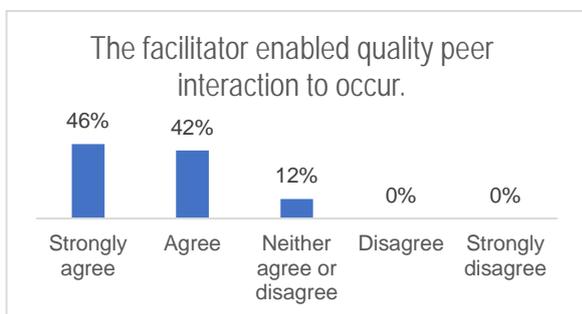
### Online format



The first question, regarding effectiveness of the **online delivery** of the training, showed strong support: 57.5% agreed and 23% strongly agreed that the method proved effective. A minority disagreed (7.5%) with slightly more neither agreed or disagreed (12%) with the statement.

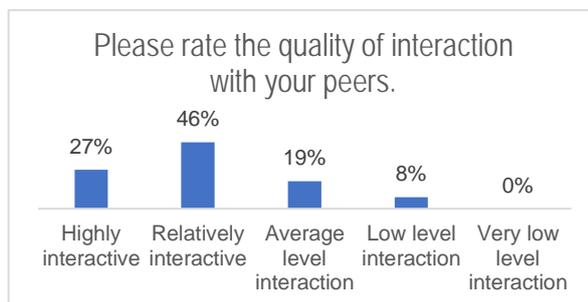
### Facilitator strengths

Participants were asked to rate the **quality of the facilitator's interaction** with the group. The majority, 62%, rated their facilitator as highly interactive, relatively interactive (23%) and of average interactivity (15%). The effectiveness of the facilitator in their ability to assist collaborative learning in this format was also tested. The majority of participants, 46%, strongly agreed and 42% agreed their facilitator effectively stimulated peer discussion.



### Peer learning

Participants were asked to rate the quality of interaction with their peers through the case-based discussion module. The majority, 46%, stated the session was **relatively interactive** while 27% stated highly interactive. Average level interaction was cited by only 19% of participants.



### Meeting learning outcomes

Participants were asked whether online case-based discussion groups helped them to improve their **CBT techniques**.

The majority of training participants supported the statement that participating in case-based discussion groups **reinforced or enhanced their learning** related to CBT with 65% strongly agreeing

and 27% agreeing. This demonstrates significant enhancement of learning outcomes through case-based discussion with a facilitator and peers.

#### *Participants' IT experience*

While there have been improvements to internet access in rural and remote areas, reliable internet access is still an ongoing barrier for many. This is a vital factor in determining the capacity to effectively deliver e-learning programs for rural GPs. To assist in assessing the impact of internet and IT related barriers to learning, training participants were surveyed regarding technical issues following completion of module 1 and again after completion of module 2.

Only 15% of participants did not experience any IT issues during module 2. The issues faced by participants included issues with the videoconferencing software (38%) and 'other' issues (38%) which primarily related to audio problems during the sessions such as audio quality, audio echoing and audio dropping out. Internet connectivity issues (35%) and network speed (27%) were more significant issues for participants during module 2. Computer hardware issues were of concern to 19%.

## **Discussion**

The RACGP Rural online FPS ST pilot survey results provide useful data to confirm some of the barriers and enablers to rural GPs accessing advanced mental health training. The survey results also demonstrated the utility of facilitated online case-based discussion groups to enhance learning outcomes, improve participant confidence in new skills and provide valuable peer interaction for rural GPs.

#### *Training access*

Finding flexible alternatives to traditional training approaches reliant on face-to-face block learning and therefore time away from practice, and finding more viable avenues to upskill became a clear focus in designing our FPS ST package. We sought to test a more accessible approach, achieved through packaged modular learning, to enable more rural GPs to acquire these skills whilst remaining in their communities. Almost half of the training participants had experienced difficulty in accessing FPS ST courses with most stating that training was not available near them, required travel to attend and required too much time away from their practices. This reinforces findings from previous RACGP Rural research<sup>1</sup> and confirms the need for further research and investment in accessible online training options for rural GPs.

#### *Modular design*

This is the first fully online FPS ST course and the degree to which the learning outcomes were met clearly demonstrated that this modular, mixed-methods delivery approach is effective for rural GPs to gain CBT skills and confidence to implement CBT-derived FPS counselling in their practices. Facilitating more choice for the learner to work through modules at their own pace and from within their community, combined with access to facilitated peer discussion supported learner satisfaction for this group. This study was therefore able to confirm a number of previously untested supportive factors in enabling accessibility for the rural GP.

#### *Participation factors*

It was important to design a package which could support rural GPs to undertake this training at their own pace and from within their community, enabling service continuity whilst encouraging participants to build connections with other professionals with a strong interest in this area. In addition to

enhancing the skills and confidence of rural GPs to deliver quality mental health care in their communities, completion of FPS-ST training is necessary in order to access higher schedule fees for FPS-counselling item numbers, and delivering an accessible training package for rural GPs ensures equity of access to these incentives. Access to the additional MBS Item numbers was a motivator for almost half the participants in our study.

Following completion of the initial 20 hour FPS-Skills Training, GPs must maintain continued professional development (CPD) activities in FPS each triennium. Consideration will need to be given regarding specific support for rural and remote GPs to maintain their FPS accreditation in future.

### ***Case-based discussion***

The evidence around the effectiveness of e-learning and blended learning approaches compared with more traditional face-to-face means has been widely demonstrated.<sup>3,6-10</sup> Offering a mix of self-directed and collaborative learning, blended models provide for flexibility while also facilitating interactive peer-to-peer learning and “action learning” to apply recently acquired knowledge.<sup>7,11</sup> However, such a model has previously been largely untested for the rural GP cohort.

The repeat-measure questions demonstrated that facilitated case-based discussion groups helped participants to solidify their learning from module 1. Increased levels of confidence to deliver effective CBT-derived FPS counselling were confirmed. Results also indicated that interaction with peers in an online format can provide a more beneficial learning experience than completing an online activity alone. The use of an expert facilitator to facilitate case discussion within the group was beneficial to the learning experience and was key to driving quality interactions.

### ***Learning communities***

Enhancing or consolidating learning through supportive learning communities including case-based discussion groups may ease issues of professional isolation and distance for rural GPs. Providing ongoing opportunities for clinical interaction with peers working in similar settings should be explored. Virtual specialist content area communities already exist for GPs including the RACGP Faculty of Specific Interests Psychological Medicine Network. Consideration could be given to formal links between the training pathway and such groups as another outcome of this training pilot.

### ***IT issues***

Despite a high number of participants experiencing IT issues during their case-based discussion module, outcome ratings remained high, lending support to the strength of the method itself. As internet connectivity continues to improve in rural areas in the future, online training will become more widely available with fewer technical barriers to impede rural GP participation. Careful selection of software that can operate effectively in cases of poor internet connectivity is advised and there may be videoconferencing software available that is better suited to use with low bandwidth internet connections.

### ***Limitations***

As this education program was the first fully online FPS ST package, it was run as a pilot with a small cohort of GPs in order to ensure acceptability and effectiveness of the model. Therefore, only a small sample size was available to complete the questionnaires and our conclusions may not be representative of all rural GPs.

## Conclusion

We demonstrated that a blended learning modular approach to mental health skills training was well received and has proven effective in the rural context for our pilot-tested online training group. The model used a mix of active group discussion, practical use of skills and online learning providing a pathway which encompasses in its design both flexibility and accessibility in approach. The facilitated case-based discussion group was found to be of particular value.

The pilot project has clearly demonstrated that a multi-modal approach with optimal e-learning mix including case-base discussion makes training more viable for the rural GP without travel or time away from their community. Prioritising and adapting this model for broader application to a range of rural advanced skill areas could be pursued as part of a priority skills investment strategy. Developing tiered incentives for GPs to acquire advanced training is important, but rurality must be considered. Accessibility and flexibility of training delivery are of critical importance for rural and remote GPs, and prioritising and adapting this model for broader application to a range of rural advanced skill areas could be pursued as part of a priority skills investment strategy.

## Acknowledgments

RACGP Rural would like to acknowledge the rural GPs who participated in the FPS ST pilot and gave their time to participate in these surveys.

Ethical approval: Reported as not applicable.

Evaluation survey through questionnaire is a standard requirement of educational continuing professional development and mandatory for the RACGP's QI&CPD program. Pilot participants were notified of the full requirements through individual interview as part of the application process.

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## Presenter

Mary Emeleus is a GP and psychotherapist part-time at headspace Cairns. She has a role with Generalist Medical Training, James Cook University as a medical educator in their GP training program (Northwest Queensland area). She has pursued a special interest in primary care mental health throughout her career as a GP in rural and regional Queensland. She has become involved in Mental Health/Counselling Skills Training for GPs and registrars over the last few years and enjoys distilling the “best bits” from psychotherapy research and practice to make them practical and relevant for GPs. Mary has recently been given the opportunity to commence training in psychiatry, and she hopes that as she progresses in that direction she can hold strongly onto her grounding as a generalist! Professional interests include lifestyle medicine, adolescent mental health, early psychosis intervention, psychological and social approaches to psychosis, “low-intensity” CBT for GPs, psychodynamic, Jungian and existential theory and practice.