PIT APPOINTMENT TOOLKIT

Assessment by 'pit stop' appointment as an alternative to full psychiatric consultation

pitproject.ca

SSC SPECIALIST SERVICES COMMITTEE
BRITISH COLUMBIA
doctors of bc
British Columbia Medical Association

Pit Appointment Toolkit

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Purpose of this Toolkit

This booklet is the essential resource for psychiatrists, family physicians, Medical Office Assistants (MOAs), and other care providers participating in **Pit Appointments**. It provides an overview, guidelines, and the necessary requirements about the method, and enables you to make an informed assessment of your interest and ability to implement Pit Appointments in your community or clinic.

Next Step: Contact Us

pitproject.psychiatry@gmail.com

Once you have reviewed the *Toolkit*, the next step is to contact us, either:

1. For more information;
2. To arrange a presentation, meeting, or discussion with your service providers to determine interest in Pit Appointments; or,
3. If you are ready to implement Pit Appointments in your community and would like to participate in a training workshop.

We look forward to hearing from you!

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“Happiness can be found even in the darkest of times, if only one remembers to turn on the light.”

ALBUS DUMBLEDORE
[Harry Potter and The Prisoner of Azkaban]

Contents

Summary

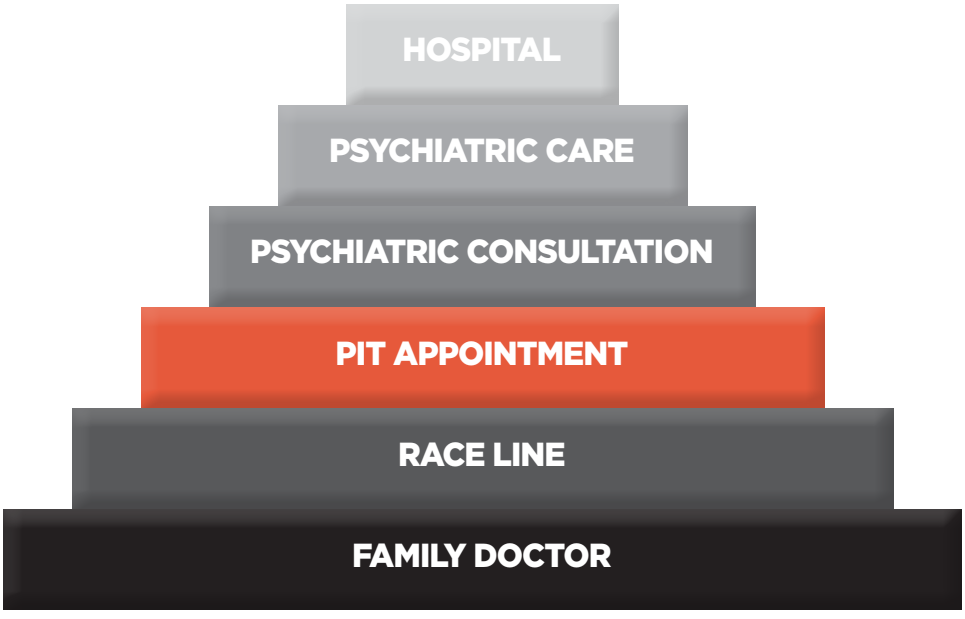
Within British Columbia's present health system, Pit Appointments are appropriate when a family physician requires a psychiatrist's perspective. It is the ideal bridge between the Race Line (telephone assessment) and full psychiatric consultation.

Pit Appointments are a new and more efficient method of assessing a patient's mental health by bringing the family doctor, psychiatrist, and patient into the same 30-minute appointment.

This strategy can benefit the community at large by helping more patients to get help sooner. It can provide more timely access to psychiatry, with fewer patients needing to use the emergency department while sitting on a wait list. Family physicians learning from psychiatrists benefits their other patients and potentially reduces the need for future consultations, thereby addressing concerns within primary care.

In order to address the rising demand for psychiatric care, collaboration between family physicians and psychiatrists is imperative. Working together, and with new interventions like Pit Appointments, we can transform the mental health system.

PIT APPOINTMENTS WITHIN THE HEALTH SYSTEM

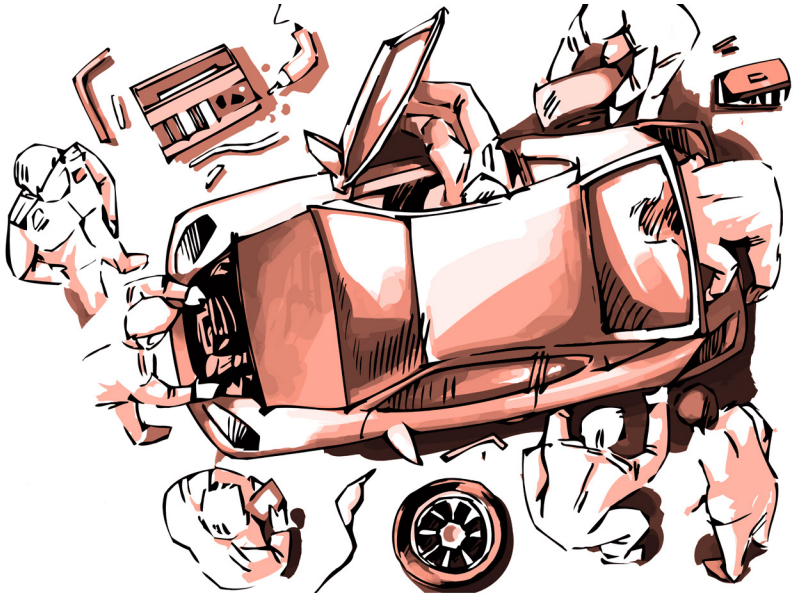


Introduction to Pit Appointments

Pit Appointments are collaborative, 30-minute psychiatric assessments that take place within a family physician's office, and that involve the family physician, a psychiatrist, and a patient.

During this compressed consultation, the psychiatrist conducts an assessment called a Pit Appointment in real time, while leveraging the existing relationship of trust between the referring physician and his/her patient.

Pit Appointments are 30-minute psychiatric assessments conducted by a psychiatrist alongside the family physician and the patient, in the GP office.



"Medical staff should function like a pit crew in a car race."

DR. ATUL GAWANDE,
TED Talk, *How Do We Heal Medicine?*
March 2012

Pit Appointments Within the Health System

When the family physician requires a psychiatrist's perspective on the patient about a specific issue, a **Pit Appointment** is the ideal bridge between a telephone assessment and a full consultation.

History & Purpose

In 2013–14 at the University of Victoria's University Health Services department, wait times for psychiatric consultation averaged 43 days (up to 217 days). By April, the clinic had 40 patients on the waiting list for psychiatric consultation. The team of health providers felt compelled to identify solutions that would help patients to receive more timely care.

In a Pit Appointment, each skilled practitioner arrives with a well-defined role, and works quickly and collaboratively to enable the patient to continue on his or her journey.

The team viewed a presentation by Dr. Atul Gawande (2012 TED Talk, *How Do We Heal Medicine?*)[1] about improving health care. Gawande proposed that medical staff should function like a pit crew in a car race. Each skilled crew member arrives with a well-defined role, and works quickly and collaboratively to enable the car to continue on its journey.

The UVIC team wondered if it could conduct these pit-stop style appointments in a way that would allow the psychiatrist to meet with a patient and a family physician, in the family physician's office, to solve problems without going through a full psychiatric consultation.

Psychiatrists felt 50 per cent of consultations could have been handled by a Pit Appointment, thereby saving time, money, and energy.

Psychiatrists felt that 50 per cent of the consultations they had completed in the previous month did not really require a full consultation and could have been handled by a Pit Appointment, thereby saving time, money, and energy. **The team then booked 36 of the 40 waiting list patients into 30-minute slots and tested the Pit Appointment method. The appointments were so successful that staff continued to conduct appointments in weekly pre-set spots.**

1 Gawande A. How do we heal medicine? TED Ideas worth spreading. Posted April 2012. Accessed 7 May 2018. www.ted.com/talks/atul_gawande_how_do_we_heal_medicine.

In 2015, the team received a grant from the Specialist Services Committee, worked to collect data, and edited its methods based on the challenges it had come to understand through conducting Pit Appointments.

Gradually, team members developed a systematic method of patient selection and referral, and finalized the Pit Appointment process.

Results

The UVic team’s project resulted in patients being seen after an average of just 10 days for a Pit Appointment. Because fewer patients required full psychiatric consults, wait times for those dropped to 15 days. Family physicians were very supportive of the method: they had learned a lot during the process, which in turn became helpful in their practice with other patients.

Psychiatrists enjoyed the method, developed better collaboration with their family physician colleagues, and saw the technique as an innovative solution potentially diverting wait listed patients from the emergency department.

While patients found the appointments very short, they appreciated the short wait times and the team approach.

Pit Appointments could be scheduled within 10 days.

Wait times for full assessments dropped to 15 days, potentially reducing emergency department patient loads.

Fewer referrals for psychiatric consultations, and more efficient patient assessments.

Benefits of Pit Appointments

Family physicians can acquire psychiatric insights about their own patients.

Family physicians refer patients to psychiatry for multiple reasons. It is clear, however, that not all referrals require a psychiatric consultation.

Psychiatric consults are at least 60 minutes in length. They involve a referral process, wait time for the consult, consult dictation, and wait time for the referring physician to receive the results. In the end, the results of the consult may or may not address the family physician's concerns that prompted the consult in the first place.

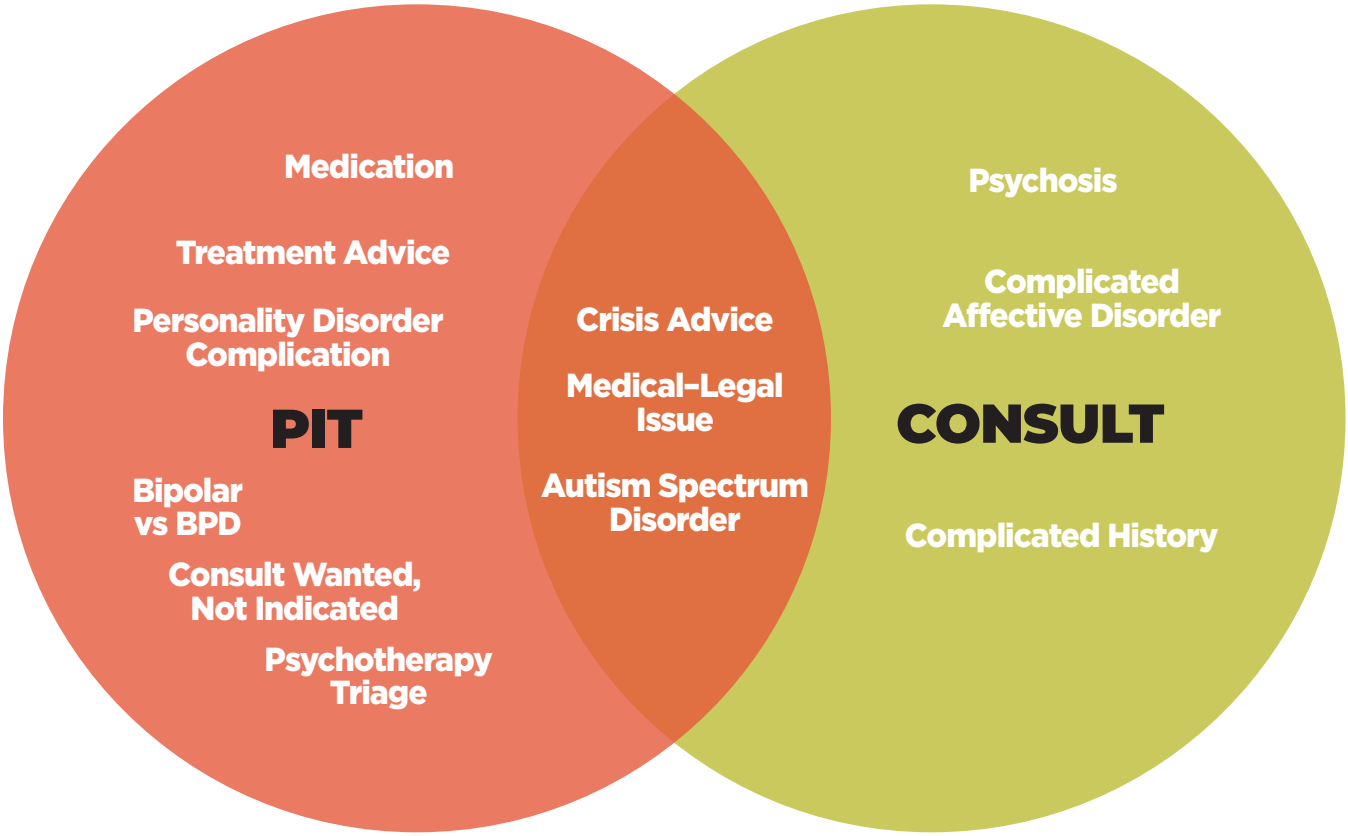
Using Pit Appointments as an alternative to full psychiatric consultation results in fewer referrals for psychiatric consultations, and the ability to assess some patients faster. Because Pit Appointments involve the referring physician, the psychiatrist, and the patient, the family physician learns in real time from the psychiatrist about the doctor's own patient. The questions of both the family physician and the patient are clearly addressed.

Patients Best Suited for Pit Appointments

APPENDIX A

The **reason for referral** determines who is best suited for Pit Appointments. This **Patient Suitability Diagram** (below, and **Appendix A**) outlines the appropriate reasons for Pit Appointment referrals, for full psychiatric consultations, and for either type of intervention.

PATIENT SUITABILITY DIAGRAM



Pit Appointment Referral Process

The process for a Pit Appointment referral includes the following steps:

1. The family physician completes a **Comprehensive Case Summary (Appendix B)** to ensure that all information is available for the appointment, and that nothing is missed.

2. Once the patient and family doctor agree to conduct a Pit Appointment, the family physician educates the patient about what to expect. A **Patient Information Sheet** is used to inform patients about the process, and to manage patient expectations **(Appendix C)**.

3. Appointments are booked efficiently based on the **Sample Schedule (Appendix D)**.

Conducting a Pit Appointment

1. The Pit Appointment takes place in the family physician's office. It begins with a five minute meeting with the family physician, who reviews the case using the Comprehensive Case Summary, and with the psychiatrist, who seeks clarification.
2. The patient then joins the family physician and the psychiatrist for a 20-minute meeting. The family physician introduces the psychiatrist, and provides the patient with a brief summary of what the psychiatrist has been told about the patient's problem.
3. The psychiatrist asks questions and explores issues, aiming specifically to answer the particular question(s) that the family physician and patient have posed.
4. The psychiatrist offers diagnoses, suggestions, and a layman's explanation.
5. A plan is established. Notably, if the next step is a full psychiatric consultation, it is best (if possible) to have the same psychiatrist conduct the consultation to provide continuity of care.
6. During the final five minutes of the appointment, the psychiatrist leaves the meeting to document findings in the medical record on behalf of both physicians. The family physician reviews the plan with the patient, writing prescriptions and scheduling follow-up as needed.

Visit the Pit Project website at pitproject.ca for a detailed summary about Pit Assessments, a webinar, a mock Pit Appointment video, and a research article that outlines the benefits of Pit Assessments (Appendix I)[1].

APPENDIX I

[On the rare occasions that the psychiatrist is not certain about next steps immediately]: Written recommendations are provided within 24 hours. The family physician then discusses these recommendations with the patient.

1 Thorpe M, Monkman H, Singh P et al. Assessment by pit appointment as an alternative to a full psychiatric consultation. BCMJ 2018; 60(6): 300-309.

Essential Requirements to Adopt the Pit Method

The following provider and funding requirements are essential in order for practitioners to adopt the Pit Method:

1. Family physicians must:
    - have established relationships with their patients; and,
    - be interested in implementing and participating in Pit Assessments with their patients.
2. A minimum of one (and for sustainability, more than one) psychiatrist must:
    - be interested in conducting Pit Appointments as an alternative to consultations; and,
    - be willing to conduct Pit Appointments on a weekly basis at the family physician's office.
3. A Medical Office Assistant must be interested in implementing the referral process in the family physicians' office.
4. Because the current system allows only the family physician or the psychiatrist to be funded through MSP, a funding arrangement must exist that enables the other practitioner to be paid, i.e., through a salaried position or alternate payment plan. Efforts are underway to establish a new billing code that would allow for both practitioners to be funded via MSP during the Pit Appointment.

1. **RECOMMENDATION:** We strongly recommend that the psychiatrist is assured that urgent psychiatric care is available by someone in the community. Despite appropriate referrals to a Pit Appointment, situations do arise where a patient will require immediate follow-up by psychiatry. If the Pit psychiatrist cannot provide such service, it is wise to establish a guaranteed backup provider.

Rules for Conducting Pit Appointments

The following guidelines are in place in order for practitioners to conduct successful Pit Appointments:

1. An established relationship must exist between the family physician and the patient.
2. The Comprehensive Case Summary must be completed.
3. Pit Appointments must start on time and end on time.
4. Both family physician and patient questions must be described precisely.
5. A Pit Appointment must end with a detailed plan. In the event that a plan requires more thought, the psychiatrist's written recommendations must be provided within 24 hours, after which the family physician must inform the patient of these recommendations.

It is essential that all family physicians conducting Pit Appointments follow each step in the process very carefully.

The Pit method relies on a trusting relationship between the patient and the family physician.

APPENDIX A

APPENDIX B

APPENDIX C

The Role of the Family Physician

The most essential component required to ensure the success of a Pit Appointment is the relationship between a family physician and the patient.

The patient's trust in the family physician, paired with that physician's knowledge of the patient, allow a psychiatrist to delve into a patient's world quickly, to obtain the required information, and to leave the relationship without harming the patient. The family physician provides a secure attachment, a holding environment*, and a continuing relationship.

The family physician must manage several tasks that are critical to the success of a Pit Appointment:

1. The family physician determines if the patient meets the criteria for a Pit Appointment, using the **Patient Suitability Diagram (Appendix A)**.
2. If the patient meets the criteria, the family physician completes the **Comprehensive Case Summary (Appendix B)**. Many family physicians find this form convenient to complete with the patient present.
3. The family physician may provide the **Patient Information Sheet (Appendix C)** to the patient.

*A 'holding environment' can be defined as a safe, trusting, secure, and supportive space.

The Importance of the Comprehensive Case Summary

There are **three** important reasons why the referral process is formalized for Pit Appointments:

1. The Comprehensive Case Summary ensures that all essential elements about a patient are recorded prior to the appointment. This completed documentation ensures that the psychiatrist does not spend the assessment period considering solutions that have already been tried.
2. When a psychiatrist documents Pit Appointment findings in a patient's chart, this referring information remains on the chart for medicolegal reasons. The information saves psychiatry time because the history has already been documented. The referral is cited at the beginning of the psychiatrist's note **(Pit Appointment Template, Appendix E)**.

Family Physician Feedback About Pit Appointments

"The usefulness of watching a psychiatrist conduct a patient history can't be overstated in discussing Pit benefits."

— Family Physician

"Pit honours the family physician–patient relationship, while enhancing the family physician's own skill set. It's a win-win."

— Family Physician

Overwhelmingly, UVic Health Services family physicians support Pit Appointments, and appreciate being able to see patients more quickly:

- They describe these appointments as timely and appropriate assessments.
- They describe learning about their patients in an atmosphere where they were not performing, but could monitor and observe.

For example, family physicians could observe a patient's vagueness or over-inclusiveness with another clinician, and could incorporate new methods to glean helpful information.

- Pit Appointments have led family physicians to feel more competent and confident in addressing mental health issues, in discussing various medications, and in eliciting information from patients.
- Family physicians have generally appreciated watching another clinician at work. One respondent commented, "The usefulness of watching a psychiatrist conduct a patient history can't be overstated in discussing Pit benefits."
- Family physicians have increased their capacity to identify characteristics of personality disorders, and to elicit coping methods from patients that could then be expanded upon in future appointments.

- One family physician stated, “Pit often helps me to answer and move forward with a patient issue that I’m stuck on. Instead of waiting months for direction or having a consult that misses the boat on the issue, I can use my knowledge and relationship with the patient to help guide a useful plan. In addition, seeing a psychiatric clinician conduct an interview builds my own capacity for interviewing skills. Pit honours the family physician–patient relationship, while enhancing the family physician’s own skill set. It’s a win-win.”
- Another stated, “Working in the Pit has helped me to hone my diagnostic acumen and confidence. The Pit has empowered me to take the time necessary to understand each patient’s symptoms in the context of unique life circumstances. As my skills have grown, I have felt more confident dealing with certain symptoms (e.g., emotional dysregulation). Pit normalizes collaboration, not only between practitioners, but with patients and practitioners. Knowing there is back-up emboldens me to make sure patients are confident in their diagnosis and treatment plans.”
- One family physician commented on the advantages of collaboration. “I appreciate being able to ask the psychiatrist clarifying or follow-up questions in real time. I always discover new things about my patients—even those I think I know well—by observing the interview.”

“Pit normalizes collaboration, not only between practitioners, but with patients and practitioners.”

— Family Physician

“I appreciate being able to ask the psychiatrist clarifying or follow-up questions in real time. I always discover new things about my patients—even those I think I know well—by observing the interview.”

— Family Physician

Reasons for a Pit Appointment

There are many reasons a family physician may recommend a Pit Appointment for a patient.

Family physicians request Pit Appointments when there are particular issues, such as when:

- they have a medication question;
- a consult has been requested by the community (e.g., the emergency department), the patient, or the patient's family, but family physician feels competent to manage the case;
- they question if the case is being complicated by a personality disorder;
- they wish to differentiate between bipolar disorder and personality disorder;
- they wish to confirm their recommended treatment; or,
- triaging for psychotherapy.

A second set of issues can be dealt with in either a Pit Appointment or consult, such as when:

- they need recommendations for crisis management;
- the situation may have potential medicolegal ramifications; or,
- psychiatric advice is required for a patient with Autistic Spectrum Disorder who has developed a psychiatric illness (e.g., depression, anxiety).

The Role of the Psychiatrist

It is essential that all psychiatrists conducting Pit Appointments follow each step in the process very carefully.

1. On the appointment date and time, the psychiatrist arrives at the family practice clinic on time.
2. The MOA provides the psychiatrist with a list of the two or three booked patients and their billing information (if the psychiatrist is billing MSP).
3. The psychiatrist proceeds to the office of the first referring family physician. This physician provides a brief to the psychiatrist about the patient history (which is also documented on the medical record as a Comprehensive Case Summary). The psychiatrist may ask clarifying questions. By the end of this interaction, the psychiatrist must understand the appointment objectives of both patient and referring physician very clearly.
4. The patient joins the referring physician and psychiatrist for 20 minutes:
    - The family physician introduces the psychiatrist to the patient.
    - The psychiatrist proceeds to elicit whatever information is required to achieve the stated objectives.
    - The psychiatrist makes suggestions and explains thoughts clearly and in layman's terms.
5. During the last five minutes, the psychiatrist leaves the family physician's office to note suggestions in the **Pit Appointment Template (Appendix E)**.
6. The psychiatrist moves on to the next patient and repeats the procedure.

APPENDIX E

Benefits for a Psychiatrist to Conduct Pit Appointments

Several advantages exist for a psychiatrist to conduct Pit Appointments:

Avoid full psychiatric consultations when unnecessary.

1. **Pit Appointments allow psychiatrists to avoid full psychiatric consultations when they are unnecessary.** Psychiatrists are often asked to conduct one-time consults. During these sessions, they may find themselves inquiring about topics such as the childhoods of a patient's parents, when the real issue pertains to the patient's need for medication to enhance the present treatment. In such a case, documenting a full consultation is time consuming and inefficient.

   In other instances, patients invest tremendous time and offer a deep level of personal details to a psychiatrist during a full consult, and register high levels of disappointment when they realize only a single visit is possible.

   Pit Appointments eliminate both of these situations by focusing in on the key issue and by managing patient expectations.

Provide timely and collaborative patient care.

2. **Pit Appointments help family physicians to conduct patient care in a timely manner.** Family physicians sometimes struggle to obtain the psychiatric advise requested in a consult note. Because the two practitioners are working together in real time, Pit Appointments ensure that the correct issues are addressed, and family physician questions are answered.

Teach family physicians in real time.

3. Pit Appointments allow psychiatrists to teach family physicians in real time.

Psychiatrists sometimes see patients for consultation where the family physician has made the correct diagnosis, but requests a psychiatrist's perspective and approval before the patient begins treatment.

Teaching within the Pit Assessment helps both the current patient and the family physician's future patients. Family physicians learn quickly; they appreciate having immediate support, receiving clarifying answers, and learning new approaches from psychiatrists.

For example, one physician worried that a patient had bipolar disorder. The physician had not elicited a family psychiatric history, which was then completed during the Pit Appointment.

Later, the family physician disclosed that he had never learned to conduct family psychiatric histories, and that at this late stage in his career he did not feel safe to ask a colleague. This feeling is not uncommon among practitioners.

During the pilot project, family physicians agreed that there is tremendous value in a Pit Appointments' ability to help them learn from psychiatrists using their own patients as examples.

Avoid emergency department visits.

4. **Pit Appointments alleviate the burden on the emergency department.**
Patients often arrive in the emergency department in a state of profound distress, having waited months for an elective, one-time psychiatric consultation to receive medication advice. Unfortunately, psychiatrists within the emergency department often cannot access the family doctor's complete patient medical records in order to ascertain a full understanding of the situation.

   Pit Appointments allow for medication consults to occur in a more timely manner, and ensure that family physicians are apprised of the complete treatment plan.

Leverage expertise in psychodynamic therapy.

5. **Pit Appointments take advantage of a psychiatrists' understanding of psychodynamic processes.**
Pit Appointments often require knowledge of personality structure, about which psychodynamic psychotherapists are well versed. Therefore, these appointments allow these psychodynamic psychotherapy experts the chance to contribute to the larger system beyond their offices, and to teach these skills to family doctors.

   By definition, patients who require complicated psychiatric medications are not seen in Pit Appointments. Pit Appointments allowed UVic clinicians to identify appropriate patients for psychotherapy who could be treated by residents or psychiatrists. Pit Assessments allow the new generation of psychiatrists who are interested in psychotherapy[1] to participate in community assessments.

1 Hadjipavlou G, Hernandez CA, Ogrodniczuk JS. Psychotherapy in Contemporary Psychiatric Practice. Can J Psychiatry. 2015; 60(6):294-300

Alleviate the need for ongoing care.

6. **Pit Appointments allow psychiatrists to see patients without the need to provide ongoing care.**
   Because family physicians follow their patients after the Pit Appointment, they are responsible for referring patients to tertiary services in the event that additional psychiatric care is required. If selected according to the guidelines provided **(See Patient Suitability Diagram, Appendix A)**, Pit patients should not require this tertiary care. In the rare event that a patient requires a second Pit Appointment, it is best to be conducted by the same psychiatrist in order to achieve continuity of care.

APPENDIX A

Provide unique options for psychiatrists at various stages of their career.

7. **Pit Appointments provide career options for psychiatrists with young families or nearing retirement.**
   Because Pit Appointment rely on the family physician, rather than the psychiatrist for patient follow-up, they are suitable for psychiatrists who are nearing retirement and still want to work but cannot undertake long-term cases. Pit Appointments are also ideal for parents of young children who wish to work without the need to be available for follow-up.[1]

1 Kurdyak, P, Zaheer J, Cheng J, et al. Changes in characteristics and practice patterns of Ontario psychiatrists: implications for access to psychiatrists. Can J Psychiatry. 2017; 62(1):41-47.

The Psychiatrist's Experience Conducting a Pit Assessment

Collaboration during the Pit Appointments leads to strong relationships between practitioners.

The Pit Appointment technique proposes a new approach that requires assessing whether the psychiatrist is able to work within the parameters, and whether the family physician is able to monitor patients over time.

Pit Appointments rely on the willingness of both practitioners to collaborate[1] in order for new and trusting professional relationships to develop.

Initial hesitation to practice in real time with another physician present is normal. Unless they are used to working in a teaching hospital, most psychiatrists have worked alone. Collaboration during the Pit Appointments leads to strong relationships between the practitioners; as each physician gains appreciation for how the other thinks, anxiety quickly dissipates.

The work is more intense than in a consultation, but is often more rewarding.

Because the family physician provides the holding environment, the psychiatrist can delve quickly into a history to obtain the information required, without having to spend time building a trusting relationship with the patient. The psychiatrist piggybacks on the established relationship between the family physician and patient. The psychiatrist arrives like a member of a pit crew in a car race, applies his or her expertise, then leaves. The work is more intense than a consultation, but is often more rewarding.

1 Gratzer D,Goldbloom D. New Government, New Opportunity, and an Old Problem with Access to Mental Health Care. Can J Psychiatry. 2017; 62(1):9

The Role of the Medical Office Assistant (MOA)

The Medical Office Assistant (MOA) is responsible for overall coordination of the Pit Appointments, including uploading and tracking the medical records in the Electronic Medical Record (EMR), scheduling, and supporting both the family physician and the psychiatrist.

It is essential that all Medical Office Assistants (MOAs) supporting Pit Appointments follow each step in the process very carefully.

UPLOAD ALL REQUIRED DOCUMENTS IN THE EMR

1. **Patient Information Sheet** as a printable form for family physicians **(Appendix C)**
2. **Comprehensive Case Summary (Appendix B)**
3. **Pit Appointment Template (Appendix E)**. The MOA must be sure to add each psychiatrist's name and credentials to his or her own template as indicated.

BLOCK PIT APPOINTMENT TIMES IN THE ER

1. **Pre-arrange** dates and times that the psychiatrist is able to attend the GP clinic.
2. Use the **Sample Schedule (Appendix D)** to block off this established Pit Appointment timeframe for all participating physicians.
3. Once the Pit Appointments have been booked, **remove the blocks** on other physician schedules to free that space for non-Pit patient appointments. It is recommended that the MOA sets personal reminders so that these essential calendar updates are completed.

SUPPORTING THE PSYCHIATRIST

1. Show the psychiatrist where the **Pit Appointment Template** can be found in the EMR, and how to retrieve it in a patient's chart.

APPENDIX A

2. Print the **Patient Suitability Diagram (Appendix A)** for the psychiatrist.
3. If the psychiatrist will be doing his or her own billing:
    - Establish a method for the psychiatrist to obtain the billing information at end of each session (e.g., provide a sheet with patient information stickers).
    - Provide the psychiatrist with a list of the referring family physicians at the clinic, along with their referral numbers, in order to set up the psychiatrists' billing.

SUPPORTING THE FAMILY PHYSICIAN

APPENDIX C

1. Show the family physician the **Patient Information Sheet** within the EMR.

APPENDIX B

2. Show the family physician the **Comprehensive Case Summary** in the EMR.

APPENDIX D

3. Show the family physician how the **Schedule** will look and work in the EMR **(Appendix D)**.

APPENDIX A

4. Print the **Patient Suitability Diagram (Appendix A)** for each family physician to post in his/her office.

Agenda for Pit Appointments

The following agenda outlines the roles of the team for each component of the Pit Appointment.

PRIOR TO PIT APPOINTMENTS

The team will:

1. Determine the dates and times on which Pit Appointments will be conducted:
   - **Time of Day:** The appointments must start and end on time. We found it easiest to schedule Pit Appointments directly after lunch.
   - **Time Required:**
     30 minutes per appointment, in blocks of two or three appointments (e.g. 60–90 minute blocks) to ensure that practitioner time is scheduled effectively.
     See note (right) re treating children and youth.*

The MOA will:

1. Pre-load documents into the EMR **(Appendices)**.
2. Use the **Sample Schedule (Appendix D)** to block Pit Appointment times based on the pre-arranged dates and times that the psychiatrist attends the clinic.
3. Support the family physician and psychiatrist (see p. 22).

*The B.C. Children's Hospital has adopted Pit Appointments through Compass, which is a province-wide service to improve access to evidence-based care for all B.C. children and youth living with mental health and substance use concerns.

Compass has determined that Pit Appointments can be conducted virtually, but that the child and youth population requires appointments longer than 30 minutes.

The Pit team advocates for continued data collection to assess the unique needs of this demographic.

APPENDIX B

APPENDIX C

ON THE DAY OF THE REFERRAL

The family physician will:

1. Book the appointment with the patient.
2. Complete the **Comprehensive Case Summary (Appendix B)**.
3. Provide the patient with the **Patient Information Sheet (Appendix C).**

DAY OF THE PIT APPOINTMENT [PRIOR TO APPOINTMENT]

The MOA will:

1. Prepare billing information for the psychiatrist

DAY OF THE PIT APPOINTMENT [DURING THE APPOINTMENT]

The family physician and psychiatrist will:

1. Discuss the referral for five minutes.
2. Have the patient join for 20 minutes.
3. During the last five minutes, the psychiatrist will leave to chart for both practitioners.
4. The family doctor will prepare scripts and future appointments as required.

Data Collection to Support Quality Improvement

In order to support the ongoing use of this method, the Pit team strongly recommends that you collect the following key outcomes as you implement Pit Appointments:

- **feedback from patients (Appendix F)**
- **feedback from family physicians (Appendix G)**
- **feedback from psychiatrists (Appendix H)**

This data will allow you to audit the process of adopting Pit Appointments in your clinic and to monitor its effectiveness. Initially, audits should be conducted biweekly and later become a monthly event.

The Pit team also has a keen interest in studying the satisfaction levels of one-time psychiatric consults; the data collected by other clinics could support this examination.

EVALUATION SUPPORT

An evaluation toolkit is in the developmental stage. Please contact the Pit team for updated procedures and templates.

Ongoing Pit Support

The Pit team is exploring methods such as online chat lines or forums to provide ongoing support to Pit crews. More information about such services will be published as they evolve in updated editions of this *Toolkit*.

The digital version of this toolkit is available for download from our website: pitproject.ca

Next Steps

STEPS FOR THE CLINIC

1. Determine that you have all essential requirements to adopt Pit Appointments in your clinic (page 8).
2. Contact the Pit team by sending an email to **pitproject.psychiatry@gmail.com** for:
   - more information;
   - to arrange a presentation, meeting, or discussion with your service providers; or,
   - to participate in a training workshop.

STEPS FOR FAMILY PHYSICIANS

1. Read pages 10–14 of this *Toolkit*.
2. Watch the CME-accredited webinar, which also includes a mock Pit Assessment: **pitproject.ca/webinars**

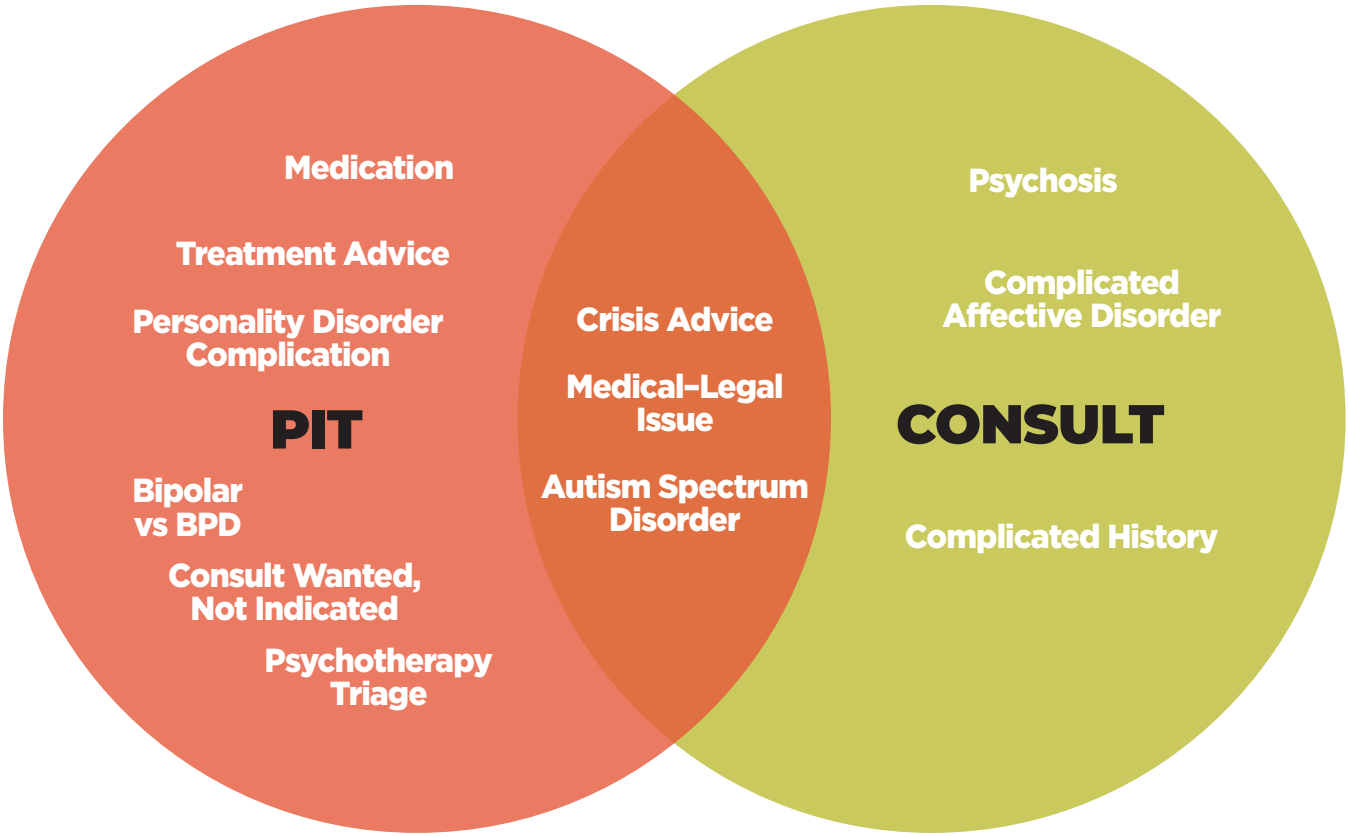
STEPS FOR PSYCHIATRISTS

1. Read pages 15–20 of this *Toolkit*.
2. Watch the mock Pit Assessment: **pitproject.ca/pit-assessments**

STEPS FOR MEDICAL OFFICE ASSISTANTS (MOAs)

1. Read pages 21–24 of this *Toolkit*.

APPENDIX A:
Patient Suitability Diagram



APPENDIX B:

Pit/Psychiatry Comprehensive Case Summary

CLIENT INFORMATION

Patient:	DOB (D/M/Y):
PHN:	Phone:
Date of Referral D/M/Y):	Referring Doctor:

Reason for Referral:
Details of Illness/Trouble:
Medications /Therapies presently underway:
Past Medications/Therapies (past psychiatric history):
Family psychiatric history:
Physical illnesses or medications to consider:
Family medical history of note:
Personal history of note:
Present life circumstances of note:
What is the referring doctor hoping for?
What is the patient hoping for?

Date booked for Pit: _____

APPENDIX C:
Pit Appointment Information Sheet

Your family doctor has decided that it would be helpful for you to have a Pit Appointment, which is a brief consultation between you, your doctor, and a psychiatrist. This information will help you to understand what to expect during your Pit Appointment, as well as about its limitations.

WHAT A PIT APPOINTMENT IS

- a 30-minute appointment
- you and your doctor will receive advice from a psychiatrist about your specific problem or issue
- Due to time limitations:
  - The psychiatrist will only be able to address one problem
  - **IMPORTANT:** You and your doctor should set a clear goal for the appointment (e.g., help with diagnosis, new medication, treatment options)

WHAT A PIT APPOINTMENT IS NOT

- It is not a full psychiatric consultation. Often, it is not necessary to consult with a psychiatrist again, or on an ongoing basis.

WHAT HAPPENS DURING A PIT APPOINTMENT?

- Your doctor will provide the psychiatrist with a brief overview of your history, and with the challenge you are currently facing (≈ five minutes).
- Then, you will join your family doctor and the psychiatrist (≈ 20 minutes).
- The psychiatrist will ask you some questions.
- You may also wish to ask some questions.
- The psychiatrist will do his/her best to help. Usually, your three-person team (including yourself) comes up with a plan during the appointment. In some cases, the psychiatrist may not have an immediate answer and may wish to think it over and follow up with your family doctor shortly.
- The psychiatrist will leave, and your doctor will discuss how you and the family doctor will proceed (≈ five minutes).

WHAT HAPPENS AFTER A PIT APPOINTMENT?

- Hopefully, you will have some new information, treatment options, or medication that will help you.
- Your care plan will incorporate the new information from this appointment.
- You will receive follow up consultation with your family doctor.

APPENDIX D:

Sample Schedule

To begin, the EMR will look like this, with Pit spots open and marked until booked:

	Dr. A	Dr. B	Dr. C	Psychiatrist
10:30				
11:00				
11:30				
12:00	LUNCH	LUNCH	LUNCH	
13:00				
13:30				
14:00				
14:30				
15:00				

As Pit Appointments are booked, the other spots are freed for non-pit patients.

	Dr. A	Dr. B	Dr. C	Psychiatrist
10:30				
11:00				
11:30				
12:00	LUNCH	LUNCH	LUNCH	
13:00	Daniels, Jack			Daniels, Jack
13:30			Down, Debbie	Down, Debbie
14:00				
14:30				
15:00				

APPENDIX E:
Pit Appointment Template

CLIENT INFORMATION

Patient:	DOB (D/M/Y):
PHN:	Phone:
Date of Referral D/M/Y):	Referring Doctor:

Date D/M/Y:

Case was reviewed with Dr _____ as per the Comprehensive Case Summary.

Plan Clarified: _____

_____

_____

_____

_____

_____

_____

Suggest: _____

_____

_____

_____

Psychiatrist: _____ Credentials: _____

APPENDIX F: PIT APPOINTMENT

Patient Feedback Form

Identification Code _____

Until recently, a psychiatrist always saw a patient alone. A psychiatrist and family doctor seeing a patient together is a new way of assessing patients to provide more coordinated care. To make this experience the best we can, we would like to hear how about your experience during your appointment by answering the questions below.

Please check the most appropriate box:	No	Somewhat	Yes
1. I felt understood.			
2. I felt more hopeful as I left.			
3. I would recommend this type of appointment for someone in my situation.			
4. I had a good understanding of my treatment and support plan.			
5. I received clear information about my medication.			
6. This appointment has helped to me deal more effectively with my challenge.			
7. I felt safe.			

What was the best thing about this appointment? _____

_____

_____

Could the appointment have been better? If so, how? _____

_____

_____

Any other comments or concerns? _____

_____

_____

_____

APPENDIX G: PIT APPOINTMENT

Family Physician Feedback Form

Code_____

We wish to evaluate Pit Appointments for ongoing quality improvement.

Referring clinician is (circle):

1. Family doctor
2. Nurse
3. Nurse Practitioner
4. Substance Abuse Counsellor
5. Pediatrician
6. Other (please specify)

Please check the most appropriate box:	No	Somewhat	Yes
1. I felt understood.			
2. I got the answer to my question.			
3. I feel competent continuing with this patient.			
4. The Pit Appointment was a good use of my time.			

Number of minutes of CME this Pit provided: _____

Would this patient have been seen for psychiatric consultation without a Pit? (circle): YES NO

If yes, how long would it take from time of referral to you receiving the consultation report?_____

What was one thing most helpful about this appointment?_____

List three things you learned during the appointment:

1. _____
2. _____
3. _____

What one thing could have made the appointment better? _____

_____

What information was most important to know before the appointment? _____

_____

Other comments _____

_____

_____

APPENDIX H: PIT APPOINTMENT

Psychiatrist Feedback Form

Pit Code_____

Type of Appointment (circle): Consult Pit

Psychiatrist _____ DIAGNOSES (codes for all)_____

Patient age _____ Sex_____ Others who attended _____
(e.g., Mom)

Type of referring clinician (e.g., family physician, social worker)_____

Check reasons for referral:

O Medication question (P)	O Psychosis (C)
O Consult wanted (by community or patient) but not indicated (P)	O Patient with long complicated history and I do not know where to start (C)
O Is this case complicated by a personality disorder? (P)	O Management of complicated affective disorder (C)
O Differentiating bipolar from borderline personality disorder (P)	O Recommendations with potential medico-legal worries (P/C)
O Am I on the right track with this patient? (P)	O Recommendations for crisis management (P/C)
O Triage for psychotherapy (P)	O Other - specify: _____

What did you do in addition to what the clinician had already done?
(e.g., more thorough family history, educate regarding medications) _____

How long did the appointment take you? Minutes for process_____ Minutes for notes_____

How appropriate was the appointment (circle)? Appropriate Inappropriate

If you think the appointment was inappropriate, why?_____

_____

_____

What is one thing would you change about this appointment?_____

_____

_____

Do you have any thoughts/feelings about this process and how to improve it? _____

_____

_____

_____

Notes

APPENDIX I:
Journal Article

Marilyn Thorpe, MD, FRCPC, Helen Monkman, MA, Pulkit Singh, MBBS, FRCPC, James Felix, MD, CCFP, Oona Hayes, MD, CCFP, Elizabeth M. Borycki, RN, PhD, Andre W. Kushniruk, PhD, Leigh E. Greiner, PhD

Assessment by pit appointment as an alternative to full psychiatric consultation

Collaborative 30-minute psychiatry consultations involving a family doctor, a psychiatrist, and a patient were rated as effective by participants and found to reduce wait times for mental health assessment at a university health clinic.

ABSTRACT

Background: **Wait times for psychiatric consultations are long, leaving many patients suffering and untreated. This was found to be a concern for students presenting with mental health issues to University Health Services at the University of Victoria, where the average wait time for a psychiatric consultation in 2013 was 43 days. In an effort to reduce wait times, University Health Services implemented a collaborative 30-minute assessment process inspired by Atul Gawande, who suggested that medical staff should function more like a pit crew in a car race when examining and treating patients. The pit appointment, developed by the Psychiatric Interdisciplinary Team Project, begins with the family doctor and psychiatrist meeting for 5 minutes; the family doctor reviews the case and the psychiatrist seeks clarification. The patient then joins them for the next 20 minutes and issues are explored, questions are posed, a diagnosis is discussed, and a treatment plan is made. During the last 5 minutes the psychiatrist leaves to complete the medical record for both physicians and the family doctor writes prescriptions and makes follow-up plans with the patient as needed. After the introduction of pit appointments in May 2014, the Psychiatric Interdisciplinary Team continued to define and refine the requirements and applications of the intervention at University Health Services and to incorporate suggestions from students and staff.**

Method: **In May 2015 data collection began for a study of pit appointments. Wait times were calculated for all students who attended a psychiatric consultation and/or a pit appointment between January 2013 and December 2016, allowing for analysis of both preimplementation and postimplementation data. Medical staff completed confidential interviews that were recorded, transcribed, and thematically analyzed. Both staff and students were surveyed about their experiences with pit appointments and their responses were reviewed and analyzed.**

Dr Thorpe was a psychiatrist at University Health Services and project lead for the Psychiatric Interdisciplinary Team (PIT) Project at the University of Victoria (UVic). She is now a clinical assistant professor in the Department of Psychiatry at the University of British Columbia and affiliate assistant professor at UVic. Ms Monkman is a PhD candidate in the School of Health Information Science at UVic and project manager for the PIT Project. Dr Singh was a resident in the Department of Psychiatry at the University of British Columbia when this article was written. Drs Felix and Hayes are family doctors and were mental health co-leads for the PIT Project. Dr Hayes is a clinical instructor in the Department of Family Practice at the University of British Columbia and an affiliate clinical instructor at UVic. Drs Borycki and Kushniruk are professors in the School of Health Information Science at UVic and co-investigators for the PIT Project. Dr Greiner is a data analyst for the PIT Project.

This article has been peer reviewed.

Assessment by pit appointment as an alternative to full psychiatric consultation

Results: **Wait times for 984 patient appointments (375 pit appointments and 609 full psychiatric consultations) were analyzed. Average wait times in 2016 were 10 days for a pit appointment, and 15 days for a consultation, a significant reduction from 43 days for a consultation in 2013. Surveys completed by 11 medical staff (psychiatrists and family doctors) and 38 students indicated the assessment process was effective, with 100% of psychiatrists and family doctors finding the intervention "somewhat helpful" or "very helpful" and 87% of students finding the intervention "somewhat helpful" or "very helpful."**

Conclusions: **Although there were several limitations to this study related to the evolving nature of the intervention and the lack of sufficient students responding to measure significance, pit appointments were found to be a cost-effective and efficient way to assess postsecondary students with mental health concerns. Potentially, this model could help many more patients receive treatment in a timely way, shorten wait times for full psychiatric consultations, lead to fewer patients requiring urgent mental health care in the emergency department, and provide a collaborative model appreciated by both psychiatrists and family doctors. Further research is needed to obtain standardized evidence of patient improvement and determine if pit appointments might be used in general practice and other clinical settings.**

Background

Atul Gawande's 2012 TED Talk about improving health care (How do we heal medicine?) proposes that medical staff should function like a pit crew in a car race, with each skilled crew member having a well-defined role and working quickly and collaboratively to enable the car to continue its journey.[1] This proposal is especially applicable to the 1 in 5 Canadians who develops a mental illness in their lifetime.[2]

Mental illness produces a tremendous burden in patient and family suffering, time lost at work, and costs of care. The economic burden of mental illness in Canada is estimated at $48 billion per year.[2] Between 25% and 50% of primary care patients have mental illness[3-6] and many patients have their first contact with the mental health system through the emergency department.[7]

Unmet needs

Despite the burden of mental illness, many Canadians do not receive any treatment at all.[2] According to the National Physician Survey, access to psychiatry services in Canada is an area of concern.[8] Wait times for psychiatric consultation are long. Traditionally, consultations have required that a patient, no matter how ill, go to a psychiatrist's office, and often there is a delay before the report on the consultation reaches the family doctor.

In a recent article about improving access to mental health care, David Gratzer and David Goldbloom recommend that psychiatrists "work more closely with family doctors, seeing their role not simply as consultants but also as educators and partners. . . . Collaborative care models are being tried across the country and are increasingly incorporated into resident teaching programs. Still, many psychiatrists and family doctors will not work in this formal structure, and stronger ties are needed."[9]

On postsecondary campuses, the mental health needs of many students remain unmet and the shortage of resources has been highlighted in the media.[10-12] Young people age 20 to 29 years have higher rates of mental illness and substance use disorders than any other age group.[2] Addressing mental health concerns in students is vital.[13] The 2013 Canadian reference group data report for the American College Health Association-National College Health Assessment II (ACHA-NCHA II)[14] found that many Canadian students reported suffering from anxiety (58%) and depressive feelings (35%) within the previous 12 months. However, only 13% reported receiving professional treatment for anxiety and 12% for depression.[14] Students at the University of Victoria reported similar rates of problematic symptoms and untreated illness in 2013.[15] Mental illness is highly detrimental to these young people, delaying or preventing their education, increasing student loan amounts, and potentially compromising students' abilities for successful futures. Timely care could treat illness faster, improve academic function and retention, and change the neurobiological course of illness in the young brain.[16]

Development of pit appointments

In 2013 the average wait time for a psychiatric consultation at University Health Services (UHS) at the University of Victoria (UVic) was 43 days. Inspired by Gawande's pit crew proposal,[1] the Psychiatric Interdisciplinary Team (PIT) Project (see www.pitproject.ca) set out to reduce long wait times for consultations and address the shortage of psychiatric resources.

Assessment by pit appointment as an alternative to full psychiatric consultation

During 2 weeks in March 2014 nearly a quarter of the patients seen by UHS family doctors (229 of 981) presented with mental health concerns. In April 2014 psychiatrists reviewed records for 24 psychiatric consultations that had been completed the previous month and determined that 12 patients (50%) had not required a full consultation. A psychiatrist and UHS family doctors then reviewed the records for 40 patients awaiting psychiatric consultation and agreed that 36 might be served by brief pit appointments. These 36 pit appointments were done in May 2014 and were deemed successful. Subsequently pit appointments were offered as an alternative to psychiatric consultation at UHS. Since the introduction of pit appointments, University Health Services staff have continued to define and refine the requirements and applications of the intervention and have incorporated suggestions from students and staff. Today, the clinical intervention that has resulted from the PIT Project begins after a patient has presented to UHS with mental health concerns. The family doctor determines if a pit appointment is appropriate, manages the patient's expectations by providing an information sheet (**Figure 1**), and then fills out a referral form (**Figure 2**). Some doctors find it useful to complete the form with the patient.

A pit appointment starts with a 5-minute meeting that allows the family doctor to review the case and the psychiatrist to seek clarification. The patient then joins the family doctor and the psychiatrist for a 20-minute meeting. The family doctor introduces the psychiatrist and gives a brief summary of what the psychiatrist has been told. The psychiatrist asks questions and explores issues, drilling down to clarify answers to the particular questions posed. A diagnosis and/or suggestions are made and a layperson's explanation is given. A plan is established. On rare occasions, if the psychiatrist is not immediately sure of next steps, written recommendations are provided within 24 hours and the family doctor informs the patient of these. Notably, if the next step is a full psychiatric consultation, an attempt is made to have the same psychiatrist do the consultation to provide continuity of care. During the final 5 minutes of the appointment, the psychiatrist leaves to complete the medical record for both physicians, and the family doctor outlines the plan with the patient, writing prescriptions and scheduling follow-up as needed.

Method

In May 2015 the PIT Project received funding from the Specialist Services Committee, one of four joint collaborative committees representing a partnership of Doctors of BC and the Ministry of Health. This funding was used to provide and evaluate services for students seeking treatment at UHS for mental health concerns (**Table 1**). After ethics approval was obtained from the UVic Human Research Ethics Board, data collection began and continued until December 2016.

Establishing wait times

Wait times were calculated for all students who received a consultation and/or a pit appointment between January 2013 and December 2016. Because pit appointments were introduced in May 2014, this allowed for the analysis of more than a year of preimplementation data and more than a year of postimplementation data. Wait times were determined by counting the days between the referral and appointment dates (i.e., for either psychiatric consultation or pit appointment).

Recording diagnostic information

Initially, diagnoses for patients seen by psychiatry were recorded using *DSM-IV-TR*[17] and *DSM-5*[18] definitions. Later, the reason for referral and whether the type of appointment given was deemed appropriate were also recorded.

Table 1. Diagnostic categories used for students seeking mental health care at University Health Services, University of Victoria.

Bipolar disorder
Pervasive developmental disorder
Anxiety disorder
Obsessive compulsive disorder
Personality disorder
Substance abuse (alcohol, prescription and street drugs)
Eating disorder
Adjustment disorder
Posttraumatic stress disorder
Sequelae of head injury
Depression
Attention deficit disorder
Psychosis (not yet diagnosed—first break) and schizophrenia
Physical disorder (e.g., hyperthyroidism)

Surveying medical staff and patients

To garner insight about the benefits and challenges of pit appointments from the care provider perspective, all clinic staff were invited to participate in confidential interviews during the development of the intervention. The interviews were recorded, transcribed, and thematically analyzed. During monthly team meetings and two annual clinic meetings, we reviewed our methods and adapted the assessment process to compensate for challenges as we acquired knowledge about this approach. After we refined

the intervention, clinic staff were surveyed anonymously for additional feedback.

To establish what patients thought of pit appointments, medical office assistants distributed flyers inviting students to participate in a survey.

Survey responses from medical staff and patients were reviewed and analyzed.

Pit honors the family physician–patient relationship while enhancing the family doctor's own skill set. It's a win-win.

Results

A total of 984 wait times (375 for pit appointments and 609 for consultations) were analyzed along with survey responses from 38 students (32 females, 6 males), average age 26.3 (SD 8.7) years. Interviews completed by 2 psychiatrists and 4 family doctors who participated in pit appointments were also analyzed, as were survey responses from 3 psychiatrists and 8 family doctors.

Wait times

Looking at the years before and after the introduction of pit appointments, wait times for a full psychiatric consultation decreased from 43 days in 2013 to 15 days in 2016, and wait times for a pit appointment averaged 10 days in 2016.

A factorial ANOVA was used to compare the main effects of appointment type (consultation or pit appointment) and year (2013, 2014, 2015, or 2016), and the interaction effect of appointment type by year on wait times. Overall, the main effect for appointment type ($F(1, 977) = 57.55$, $P < .001$), year ($F(3, 977) = 39.43$, $P < .001$), and the interaction between appointment type and year ($F(2, 977) = 9.27$, $P < .001$) were significant. On average, participants had shorter wait times measured in days for pit appointments (mean 10.8, SE 1.2) than for consultations (mean 28.8, SE 1.01), wait times on the whole decreased significantly between 2013 (mean 42.8, SE 1.6) and 2016 (mean 12.41, SD 1.3), and average wait times for consultation decreased at a faster rate between 2014 (mean 34.5, SE 1.8) and 2016 (mean 15.1, SE = 1.9) than did wait times for pit appointments between 2014 (mean 11.7, SE 2.4) and 2016 (mean 9.7, SE 1.9) (Figure 3).

Referral reasons

Diagnoses were not found to be significantly different when comparing patients assessed by pit appointment with those assessed by full psychiatric consultation. The average number of diagnoses for patients who had pit appointments (mean 1.55, SD 0.84) and consultations (mean 1.78, SD 0.90) were similar, with both falling between one and two. Diagnoses alone did not prove valuable for identifying patients best served by pit appointments. However, appropriate reasons for referring a patient for a pit

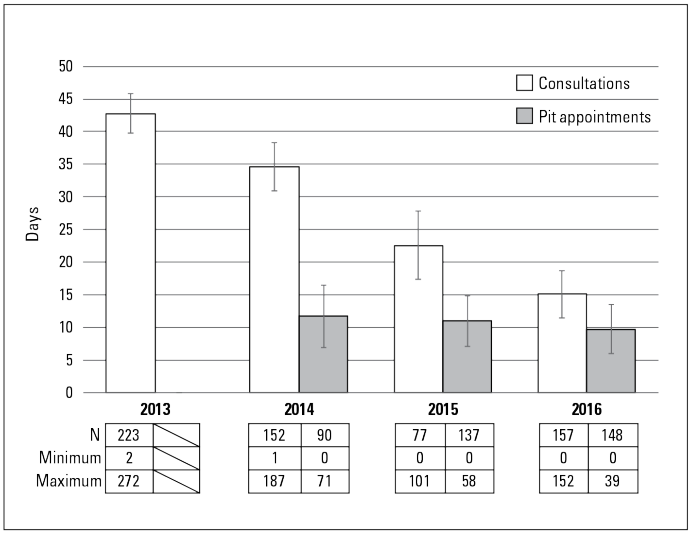


Figure 3. Average wait times for psychiatric consultations and pit appointments by year, 2013 to 2016 (pit appointments introduced in 2014).

appointment or a psychiatric consultation were identified in the course of the study as findings were monitored, refined, and shared among physicians and psychiatrists (Table 2).

Rating pit appointments

When rating pit appointments, 33 of 38 patients (87%) found their assessments "somewhat helpful" or "very helpful," while 27% of physicians found them "somewhat helpful" and 73% found them "very helpful."

A majority of patients agreed or strongly agreed with the following statements:

- I felt understood (32/42 = 76%).
- I felt more hopeful as I left (26/38 = 68%).
- I would recommend this type of appointment for someone with my trouble (30/40 = 75%).
- I had a good understanding of my treatment and support plan (34/44 = 77%).
- I received clear information about my medication (28/36 = 78%).
- The services I received have helped me deal more effectively with life's challenges (40/54 = 74%).

Conclusions

Survey and interview responses from psychiatrists, family doctors, and patients about the value of pit appointments were generally positive. Although challenges to wider implementation exist and further research is needed, study results suggest that pit appointments could be useful for other postsecondary institutions and family practices at large, and could result in more timely treatment and other benefits.

Psychiatrist comments

Interviews with UHS staff during the development of pit appointments revealed that psychiatrists and family doctors were not familiar with each other, and they described feeling like "being back in medical school" and performing under the scrutiny of a colleague. This quickly dissipated. As working relationships continued over time, trust and understanding developed and the ability of staff members to collaborate with each other and with patients was enhanced.

Psychiatrists found pit appointments preferable to consultations in the emergency department because of access to the family doctor's information about the patient and the patient's illness. Unlike emergency department assessments, pit appointments are not typically done in a crisis and this allows medical staff to gain a more coherent understanding of the patient's difficulties. The patient is also likely to be more forthcoming and less alarmed about being "sick enough to see a psychiatrist" during a pit appointment because it is held in a familiar place with a family doctor that the patient already knows and trusts participating in the assessment. There is also greater satisfaction for the psychiatrist, who knows that the patient will receive appropriate and immediate follow-up care.

One psychiatrist commented that the "fast" and intense 20 minutes with the patient requires the use of "clinical acumen, judgment, and experience toward what one sees and hears from the patient. Pit appointments rely on my complete knowledge in a whole new way."

Family doctor comments

Family doctors interviewed for the study commented that pit appointments lead to them feeling more competent and confident about mental health issues, various medications, and how to elicit information from patients. One respondent said that the usefulness of "watching a psychiatrist do a history can't be overstated in discussing pit benefits," and family doctors generally appreciated watching another clinician at work.

Family doctors also described acquiring increased capacity to identify characteristics of personality disorders and to elicit coping methods from patients that they can then expand upon.

One family doctor stated, "Pit often helps me answer and move forward

Table 2. Appropriate reasons for referral for pit appointment, for full psychiatric consultation, and for either.

	Reasons
Referral for pit appointment	• Medication question • Consultation wanted by community or patient, but not indicated • Triage for psychotherapy • Need to determine if case is being complicated by a personality disorder • Need to differentiate bipolar disorder from personality disorder • Need to determine if patient is on the right track with treatment
Referral for psychiatric consultation	• Psychosis indicated • Management needed for complicated affective disorder • Patient has long, complicated history and family doctor does not know where to start
Referral for either	• Recommendations needed for crisis management • Recommendations needed for case with potential medicolegal worries • Autism spectrum disorder suspected (patient tolerance specific)

with an issue that I'm stuck on with a patient. Instead of waiting months for direction or having a consult that misses the boat on the issue, I can use my knowledge and relationship with the patient to help guide a useful plan. In addition, seeing a psychiatric clinician conduct an interview builds my own capacity for interviewing skills. Pit honors the family physician–patient relationship while enhancing the family doctor's own skill set. It's a win-win."

Another stated, "Working in the pit has helped me hone my diagnostic acumen and confidence. The pit has empowered me to take the time necessary to understand each patient's symptoms in the context of unique life circumstances. As my skills have grown, I have felt more confident dealing with certain symptoms (e.g., emotional dysregulation). The pit normalizes collaboration, not only between practitioners, but with patients and practitioners. Knowing there is backup emboldens me to make sure patients are confident in their diagnosis and treatment plans."

Yet another family doctor commented on the advantages of collaboration: "I appreciate being able to ask the psychiatrist clarifying or follow-up questions in real time. I find I always discover new things about my patients, even those I think I know well, by observing the interview."

Patient comments

Students surveyed about their pit appointment experience made positive comments such as the following:

- "Because I was in a crisis . . . [I had a pit] instead of waiting for [a] consultation. I'm glad that they realized how important it was for me to start seeing someone immediately."
- "It really helped me to feel supported, as if there really is a team of doctors willing to help me."
- "It was nice that the referring physician had already briefed the psychiatrist regarding my condition and concerns."

Negative comments about pit appointments commonly focused on their brief nature (e.g., "short and rushed"). However, most students (18 of 23) preferred having a shorter wait for a pit appointment than having a longer wait for a full psychiatric consultation.

The dramatic reduction in wait times for psychiatric input has been very rewarding for both clinicians and patients.

Pit appointment benefits and challenges

Pit appointments evolved from the grass roots wishes and needs of clinicians at UHS, which in turn meant staff provided significant support to the PIT Project and this permitted rapid initiation and integration of new ideas without the resistance sometimes encountered in an organization.

The dramatic reduction in wait times for psychiatric input has been very rewarding for both clinicians and patients.

In 2016 the National College Health Assessment for UVic[19] reported that the proportion of patients receiving professional treatment for anxiety was 30% (versus 14% in 2013[15]) and for depression the proportion was 16% (versus 11% in 2013[15]). It is possible that the lack of delay in scheduling appointments played a part in this, along with the fact that fewer "no shows" occurred compared with 2013 and fewer patients were "no longer interested" or "unable to be located" with the introduction of faster services.

We believe pit appointments could benefit the community at large by helping more patients get help sooner. Fewer patients would need to use the emergency department. Fewer psychiatric consultations would be required and therefore wait lists would be shorter. The positive effects of family doctors learning from psychiatrists would also benefit other patients. In addition, the collaboration of family doctors and psychiatrists might inspire the development of new interventions.

Certainly this method of assessment is appreciated by medical staff at UHS and could support family doctors and psychiatrists developing the "stronger ties" recommended by Gratzer and Goldbloom.[9] Pit appointments allow psychiatrists to teach family doctors in real time with their own patients. Also, participating in

pit appointments could be appropriate for semi-retired psychiatrists or those with young families, since there is no ongoing responsibility for care.[20] Pit appointments could also allow the younger generation of psychiatrists interested in psychotherapy practices[21] to continue to participate in community assessments.

One challenge to the wider adoption of pit appointments is funding for family doctors, who typically do not have fee codes for shared care. In some provinces, two doctors are prohibited from billing for the same patient on the same day. While this is not an issue at UHS, where family doctors are on salary, it is an issue elsewhere and governments will need to consider alternative funding models to facilitate the use of pit appointments. Currently in BC, the fee billed by a psychiatrist doing a pit appointment is half that billed for a full psychiatric consultation and requires less documentation. Dealing with the funding challenge is worthwhile, however, given that pit appointments could be useful for other postsecondary institutions and family practices at large, and could result in more timely treatment, decreased length of psychiatric illness, improved lives of patients, fewer patients using the emergency department, and shorter wait times for those requiring full psychiatric consultations.

Limitations of study

The study was affected by a number of limitations, including the lack of measurement before and after pit appointments to provide standardized evidence of patient improvement. As well, students seeking treatment at UHS were approached to participate in the study through invitation flyers distributed by medical office assistants. While this preserved confidentiality and participant anonymity, it meant we could not identify all potential participants and were unable to obtain a reliable response rate.

In addition, our study was limited by the fact that pit appointments were evaluated in conjunction with other new mental health interventions at UHS, including the introduction of a full-time mental health nurse, on-site cognitive behavioral therapy, a set of Managing Emotions modules offered in semester blocks for students with dysregulated emotions, and a focus group for students with diabetes and mental health issues.[22] Survey respondents were asked to provide feedback on all types of mental health appointments they had attended at UHS, and many respondents who provided feedback had attended pit appointments weeks or months before completing the survey. With few participants having attended a pit appointment as their most recent UHS intervention, we were unable to provide reliable estimates of outcome measures.

Before the introduction of pit appointments, patients received one-time-only mental health appointments. Anecdotally, both psychiatrists and patients found one-time-only consultations unsatisfying, as patients had typically waited for an extended period hoping for longer-term treatment, which was not offered. No data about satisfaction with one-time-only psychiatry consultations were collected before pit implementation, nor could such data be found in the literature.

Pit appointments were introduced a year before any data collection began. By the time patients receiving psychiatric consultations were surveyed, they were by definition more severely ill or had more complicated illness and needed more than one session with a psychiatrist. Thus, patients who received consultations went on to receive more care and to develop a therapeutic relationship with the psychiatrist. This was not true for patients who received pit appointments and, therefore, a direct comparison between those who attended pit appointments and those who attended consultations would not be prudent, as the populations and treatments are now inherently different.

Further research

Further research is needed to determine if pit appointments can be used in diverse clinical settings, including general practice clinics. Research might also determine if pit appointments are useful only for young adults without long and complicated histories, even though psychiatrists working in emergency departments suggest this is unlikely, since they often see patients in need of medication suggestions who have deteriorated significantly while on psychiatry wait lists. As well, the study of more detailed performance indicators could elucidate the effectiveness of pit appointments, and the study of implementation in different clinical settings could establish how a clinic's culture influences the introduction of this intervention.

Summary

The collaborative pit appointment introduced at University Health Services in May 2014 was found to reduce wait times significantly for students with mental health concerns. Most psychiatrists, family doctors, and patients who participated made positive comments about the intervention. Pit appointments at UHS were deemed to be cost-effective and to increase the knowledge, abilities, and confidence of family doctors treating mental health disorders. BCMJ

Acknowledgments

The development of pit appointments resulted from collaboration by the team

Assessment by pit appointment as an alternative to full psychiatric consultation

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Competing interests

None declared.

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