CBT Skills Groups Spread Initiative

Year 1 Evaluation Report

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Submitted To:

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Acknowledgements

The Reichert & Associates Evaluation Team would like to respectfully acknowledge our office is located on the unceded traditional territory of the Coast Salish Peoples, including the traditional territories of xʷməθkwəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and Səl̓ílwətaɬ (Tsleil-Waututh) Nations. We are honored to be evaluating the CBT Skills Groups Spread Initiative and would like to express our gratitude to the many physicians, other care providers, patients, staff and initiative partners who shared their knowledge, experience and time throughout the evaluation. Our team employed strategies to ensure informed consent throughout all data collection activities, provide appropriate compensation and share back findings for approval prior to their use in evaluation reporting.

Executive Summary

About this Report

This report presents evaluation findings from Year 1 of the CBT Skills Groups Spread Initiative (the initiative), which spans from October 1, 2021, to September 30, 2022. The initiative involves spreading a successful Cognitive Behavioural Therapy (CBT) based group program across BC with the stated goals of 1) improving physician wellness through CBT training, training physicians to deliver CBT skills to patients in group settings and increasing patient access to CBT-informed treatment.

Implementation of the initiative

The initiative is sponsored by Shared Care and governed in collaboration with UBC Continuing Professional Development (UBC CPD), who aims to **offer physician wellness (Phase 1 CBT training) to 240 physicians**, the CBT Skills Groups Society (Skills Society), who coordinates patient CBT Skills Groups and **aims to train 100 physicians to become CBT Skills Groups facilitators** and an Advisory Committee, comprised of key partners able to provide advice on the initiative. The key implementation findings from Year 1 are highlighted below:

Key Finding	Details
248 physicians, residents and nurse practitioners have registered for physician wellness / Phase 1 CBT training	• 76% (189 of 248) of those registered are family physicians • **125 family physicians have completed the training out of the 240 targeted** *(based on UBC CPD attendance data of training groups completed by September 30, 2022)*
37 family physicians are in Phases 2-4 of training	• Phases 2-4 training, offered by the Skills Society, trains family physicians to become CBT Skills Groups facilitators. It typically takes more than a year to complete this training; **37 family physicians are currently in training out of the 100 targeted**
5,882 patients referred to CBT Skills Groups	• 1,486 different primary care providers made these referrals • Referrals are from across the province; most referrals are from the Island Health Region, primarily from the Victoria, South Island and Vancouver Divisions of Family Practice
2,423 patients registered for a CBT Skills Foundations group	• Patients are participating from across the province; most patients are from the Island Health Region, primarily from the Victoria and South Island Divisions of Family Practice • 77% of these patients completed the group (attended 8 or more sessions); 20% partially completed the group (less than 6 sessions)

Impacts of the initiative

The initiative has been found to positively impact those participating in CBT training, patients participating in CBT Skills Groups and the primary care providers that have referred these patients. **Outcomes are similar to those documented in prior year CBT Skills Groups program data.** The key impacts of Year 1 are highlighted below:

Physician Wellness / Phase 1 physician participants	Patient CBT Skills Groups participants	Primary care providers who referred patients
Increase in professional fulfillment and decreases in work exhaustion	**Decrease in depression and anxiety and an increase in**	Early findings from the referring provider survey, launched shortly

and interpersonal disengagement across participants who completed the Stanford Professional Fulfillment Index (n=35), a validated scale completed before and after the training.	**resilience** across participants who completed the Patient Health Questionnaire 8 (n=657), the Generalized Anxiety Disorder 7 (n=666) and the Brief Resilience Scale (n=167), respectively, at the start and end of the program.	before this report, indicate that primary care providers agree that the program **gave their patients greater and faster access to mental health care .**
97% (n=126) and 94% (n=125) of participant survey respondents (n=126) **will use the CBT skills they learned in their personal life and in their professional life**, respectively	84% of patient survey respondents (n=1947) agreed **their ability to manage their mental health symptoms has improved** as a result of the program	Early findings from the referring provider survey, launched shortly before this report, indicate that primary care providers agreed **the program has improved their ability to work with patients and have decreased the urgency and frequency of appointments** with these patients
94% and 93% of participant survey respondents (n=127) **will recommend the program to colleagues and patients**, respectively	95% of patient survey respondents (n=2725) **would recommend the program to friends and family**	Early findings from the referring provider survey, launched shortly before this report, indicate that referring providers **would recommend the program to other primary care providers**

No significant changes were detected across key performance indicators, such as participant satisfaction and patient health outcomes, from prior year CBT Skills Groups program data and **no significant differences were detected across the satisfaction and experience of patient CBT Skills Groups participants from different backgrounds and lived experiences**. Patients did however offer suggestions on how the program can continue to improve in this area moving forward.

The successes of Year 1, despite taking place amidst a crisis in primary care was attributed, by initiative partner interviewees, to the **strong relationships that have been built**, both internally with the Skills Society and UBC CPD and with external partners, such as the Divisions of Family Practice and regional Health Authorities. Interviewees also credited success to **having the Skills Society centralize administration** for the program and **having UBC CPD deliver the physician wellness / Phase 1 of CBT training**. **Offering CBT training and CBT Skills Groups virtually has also helped to quickly scale the initiative**. The key challenges cited by interviewees was that it took time to build these relationships and infrastructure.

Discussion

Year 1 of the initiative saw **high demand for and uptake of Physician Wellness / Phase 1 training** across the province and **positive outcomes for trainees, primary care providers referring patients and participating patients**. Evidence also suggests the **integrity of the CBT Skills Groups program has been maintained** during the spread, that **program capacity to offer patient groups is increasing** and that the program is **meeting an important need in the health system**.

Conclusion

Overall, the CBT Skills Groups Spread initiative is successfully meeting its goals and objectives of 1) improving physician wellness through CBT training; 2) training physicians to deliver CBT to patients in group settings and 3) increasing patient access to CBT-informed treatment.

List of Abbreviations

CBT	Cognitive Behavioural Therapy
MRP	Most Responsible Provider
PCN	Primary Care Network
PHP	Physician Health Program
Skills Society	CBT Skills Groups Society
SCC	Shared Care Committee
UBC CPD	University of British Columbia Continuing Professional Development

Terminology

Throughout this report the following terminology will be used to describe the initiative:

Physician Wellness Participants – Physicians, nurse practitioners and / or residents who registered for and / or completed UBC CPD physician wellness training. Participants may or may not be interested in becoming / eligible to become a CBT Skills Groups Facilitator.

Phase 1 Trainees – Family physicians who registered for and / or completed Phase 1 of the training who indicated being interested in becoming a CBT Skills Groups Facilitator.

Phase 2-4 Trainees – Family physicians who completed Phase 1 of the training, expressed interest in and were selected by the CBT Skills Groups Training Committee to register for and / or complete Phase 2-4 of the training.

Phase 5 Trainees – A CBT Skills Groups Facilitator who has solo-facilitated 5 CBT Skills Groups is eligible for Phase 5 which involves equal co-facilitation with mentor to consolidate learning.[1]

CBT Skills Group – an 8-week psycho-educational class for adults, aged 17.5 and older, designed by psychiatrists and taught by physicians

CBT Skills Groups Facilitator – A Phase 2-4 trainee that has successfully completed Phase 4 of CBT Skills Groups training and is qualified to facilitate CBT Skills Groups to patients.

CBT Skills Groups Trainer – An experienced CBT Skills Groups Facilitator (psychiatrist and / or family physician) who is qualified to deliver CBT Skills Group training (Phase 1, 2, 3) to other physicians.

Referring provider – A primary care provider who referred their patient to participate in a CBT Skills Group.

Participating patients – Patients who were referred by their Most Responsible Provider (MRP) to partake in a CBT Skills Group and registered for, attended, and /or completed a CBT Skills Group.

[1] *Phase 5 training has not yet been implemented and will not be formally assessed in this evaluation.*

Validated Tools

The following tools are also used by the Skills Society and used by the evaluation:

The Patient Health Questionnaire 9 (PHQ-9)[2] is a 9-item instrument for screening, diagnosing, monitoring and measuring the severity of depression. Responders are asked to rate the frequency of depression symptoms in the last 2 weeks on a Likert scale ranging from 0-3. Items are summed to provide a total score. In terms of the depression severity, a score of 1-9 is considered 'minimal, 10-14 mild, 15-19 Moderate, 20-24 Severe. This tool is used by the Skills Society to assess patient eligibility for the program; only patients with a score of 18 or less are eligible.

The Patient Health Questionnaire 8 (PHQ-8)[3] is an 8-item instrument for screening, diagnosing, monitoring and measuring the severity of depression. Responders are asked to rate the frequency of depression symptoms in the last 2 weeks on a Likert scale ranging from 0-3. Items are summed to provide a total score. In terms of the depression severity, a score of 1-9 is considered 'minimal, 10-14 mild, 15-19 Moderate, 20-24 Severe. Only patients with a score of 18 or less at time of referral are eligible to register for CBT Skills Groups. This tool is used by the Skills Society with patients.

The Generalized Anxiety Disorder 7 (GAD-7)[4] is a 7-item questionnaire for screening and severity measuring of generalized anxiety disorder (GAD). The GAD-7 score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of 'not at all', 'several days', 'more than half the days', and 'nearly every day', respectively, and adding together the scores for the seven questions. Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate, and severe anxiety, respectively. This tool is used by the Skills Society with patients.

The Stanford Professional Fulfilment Index (PFI)[5] is a 16-item instrument that covers burnout (work exhaustion and interpersonal disengagement) and professional fulfilment. Response options are on a five-point Likert scale. Scale scores are calculated by averaging the item scores of all the items within the corresponding scale. Higher score on the professional fulfilment scale is more favourable. In contrast, higher scores on the work exhaustion or interpersonal disengagement scales are less favourable. This tool is used by the Skills Society with Physician Wellness participants and Phase 1 trainees, it is also planned for use with Phase 2-5 trainees and facilitators.

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[2] *Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. 2001 Sep;16(9):606-13. Doi: 10.1046/j.1525-1497.2001.016009606.x. Accessed November, 22, 2022 at https://pubmed.ncbi.nlm.nih.gov/11556941/*

[3] *Kroenke K, Strine TW, Spitzer RL, Williams JB, Berry JT, Mokdad AH. The PHQ-8 as a measure of current depression in the general population. J Affect Disord. 2009 Apr;114(1-3):163-73. doi: 10.1016/j.jad.2008.06.026. Epub 2008 Aug 27. PMID: 18752852. Accessed April 20, 2022 at https://pubmed.ncbi.nlm.nih.gov/18752852/*

[4] *Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22 166(10):1092-7. Access November 22, 2022, at https://pubmed.ncbi.nlm.nih.gov/16717171/*

[5] *The Stanford Model of Professional FulfillmentTM is a conceptual and visual model intended to assist in assessing and improving physician wellness. © 2016 Board of Trustees of the Leland Stanford Junior University. All rights reserved. Accessed April 20, 2022, at https://wellmd.stanford.edu/about/model-external.html*

The Brief Resilience Scale (BRS)[6] is a 6-item, self-reported measure of an individual's ability to bounce back or recover from stress such as after a stressful event or life's setbacks. Response options are on a five-point Likert scale. Scale scores are calculated by adding the value (1-5) of responses for all six items (creating a range from 6-30) and dividing the sum by the total number of questions answered (6) for a final score. A score from 1.00-2.99 is considered Low resilience, 3.00-4.30 normal resilience and 4.31 – 5.00 High resilience. This tool is used by the Skills Society with patients, Physician Wellness participants, Phase 1 trainees and is also planned for use with Phase 2-5 trainees and facilitators.

About the CBT Skills Groups

The Cognitive Behavioural Therapy Skills Groups Program (CBT Skills Groups Program) was established to spread a successful CBT-based group program created in 2015 by a small group of physicians in Victoria supported by the Shared Care Committee (SCC) and the Victoria Division of Family Practice. This team built a curriculum for primary care patients with mild to moderate anxiety and depression, which could be delivered through 90-minute group medical visits over eight consecutive weeks. A sustainable delivery model was created that capitalized on physician facilitators and accommodated training of new physicians through co-facilitation in ongoing patient groups.

Figure 1. Overview of the CBT Skills Groups delivery model

About the CBT Skills Groups Spread Initiative

Over the course of January 2022 to July 2023, the initiative, funded by the SCC, a joint collaborative committee of the Doctors of BC and the Ministry of Health, is spreading the CBT Skills Groups Program across the province to enroll 240 physicians to complete the UBC Continuing Professional Development (UBC CPD) Physician Wellness training (Phase 1 of the model) and enroll 100 physicians to complete advanced training for CBT Skills Groups delivery (Phases 2-4 of the model, offered by the Skills Society), becoming CBT Skills Groups Facilitators.

The stated goals of the spread initiative are to 1) **improve physician wellness** through CBT training; 2) **train physicians to deliver CBT** to patients in group settings and 3) **increase patient access** to CBT-informed treatment.

About the Evaluation

The evaluation is designed to collect formative and summative findings. That is, the evaluation has been designed to provide an opportunity to comment on the processes that support the spread initiative, as well as

[6] *Smith, B.W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P. and Bernard, J. (2008). The Brief Resilience Scale: Assessing the Ability to Bounce Back. International Journal of Behavioral Medicine, 15, 194-200. Accessed April 20, 2022, at https://mcwell.nd.edu/assets/400953/brs.pdf?msclkid=9addc5a3c0c611ecb1feed9b29922287*

the impacts of the initiative as they relate to stated goals and objectives. The evaluation's intent is to provide feedback that will contribute to decision making and highlight learnings for the future.

With this approach, the evaluation addresses the following key questions:

PROCESS EVALUATION	1. How was the initiative implemented? 2. What was implemented over the course of the initiative?
OUTCOME EVALUATION	3. To what extent has the initiative achieved its intended objectives? 4. Was the integrity of CBT Skills Groups program maintained throughout the initiative? 5. What are the lessons learned from the initiative that can inform the sustainability of the CBT Skills Groups program and its further integration within the health system?

Methods

Method		Detail/Stakeholder
	**Document Review:** to understand the development and operations of the initiative.	• Skills Society materials (e.g., Patient Referral Form, Patient Inclusion / Exclusion Criteria)
	**Administrative Data Review:** to document the activities of the initiative including who is participating in CBT Skills Groups / CBT Skills Training. *Available historical admin data, pre-dating the start of the initiative (October 2021) was also analysed to assess whether the integrity of the CBT Skills Groups / CBT Skills Training has been maintained*	• Skills Society Access Database, which records all patient, referring provider, trainee and facilitator activities • UBC CPD Physician Wellness data, which records all Physician Wellness activities
	**Key Informant Interviews**: to understand implementation and impacts/lessons learned from the perspective of key partners of the initiative.	• CBT Advisory Committee members (n=7) including CBT Skills Society, Doctors of BC, UBC CPD, Physician Health Program and physician representatives) • Skills Society staff (n=1) • Division of Family Practice staff (n=2) • Referring providers (n=4)

	**Surveys:** to understand the experience and satisfaction of those participating in CBT Skills Groups / CBT Skills Training. The evaluation	• Patients
		  ○ Pre program survey (n=1036)
		  ○ Final Evaluation survey (n=2729)
		• Phase 1 Trainees
		  ○ Pre program survey (n=201)

	leveraged existing surveys offered by the Skills Society. *Available historical survey data, pre-dating the start of the initiative (October 2021) was also analysed to assess whether the integrity of the CBT Skills Groups / CBT Skills Training has been maintained.*	○ Post Program / Final Evaluation survey (n=136) • Phase 2-4 Trainees ○ Competency assessment survey (n=9) ○ Phase 3 Evaluation survey[7] (n=14) • Referring Provider survey[8] (n=16)
	**Focus Groups:** 3* Focus groups were held with patients who have participated in a CBT Skills Group (*1 of the 3 focus groups became a one on one interview due to participants cancelling last minute)	• Patients (n=7)

Limitations

Methodology-related limitations

The evaluation relies on voluntary key informant interviews, focus groups and surveys. Participants may not be entirely objective and may be subject to recall errors. The evaluation has sought to mitigate this limitation by using a variety of data collection methods and by seeking input across a wide variety of stakeholders, and, where possible / appropriate, asking similar questions across different stakeholders.

Survey data limitations

The evaluation has also leveraged data from existing survey tools used by the Skills Society as part of their ongoing assessment of patient groups, Phases 2-4 of training and their facilitators. These surveys are distributed and administered by the Skills Society and are always open which makes it difficult to calculate a response rate. Survey questions were added to accommodate the needs of the evaluation in Spring/Summer of 2022 therefore the total number of survey responses received per question / statement will vary. Non response bias from survey data is also a possibility, as it is uncertain if participants who did not complete the voluntary surveys had similar or different experiences with the program from those who did complete the surveys. The evaluation aims to mitigate this limitation by presenting the number of responses received / analysed per question / statement wherever possible.

Administrative data limitations

The evaluation has also leveraged data from the Skills Society Access Database which houses records of all patients, referring providers, trainees and facilitators who have participated in the program since 2015. The Access Database is a live database, meaning that data entry by Skills Society staff is ongoing and may be subject to data entry changes, errors or delays in data entry. The evaluation team has sought to mitigate this

[7] *This survey is distributed to trainees once they completed Phase 3 of training. At the time of writing this report there are 13 physicians in Phase 3 or 4. Please see the Limitations sections for more information regarding survey response rates.*

[8] *This survey was launched in Oct 2022, a month before this evaluation report was prepared, to referring providers of one Division of Family Practice. The Skills Society has since distributed the survey to all referring providers by fax, posted the survey in the Divisions Dispatch and requested several Divisions of Family Practice to share the survey with their members.*

limitation by excluding data that did not appear clean or complete. The evaluation also decided to report on the newest data available; data in this report may not match quarterly reports previously submitted.

Self-report limitations

Lastly, the Skills Society administers the Patient Health Questionnaire 8 (PHQ-8) and the Generalized Anxiety Disorder 7 (GAD-7) questionnaire to patients, the Stanford Professional Fulfillment Index (PFI) to Phase 1 / Physician Wellness participants and the Brief Resilience Scale to both patients and Phase 1 / Physician Wellness participants (new as of Spring 2022) at the start and end of their group / program. Responses are collected by the Skills Society using an online survey and responses are self-reported. There may be limitations associated with using self-reported scales (such as recall bias or social desirability bias), the scales chosen for this evaluation are validated, and are commonly used and accepted in research. Not all participants completed both the baseline and follow-up psychometric scales. Participants who did not complete the scale at both baseline and follow-up were excluded from the analysis; all pre post analyses are based on matched participant data, allowing for the assessment of participant-level changes from pre to post program.

Findings

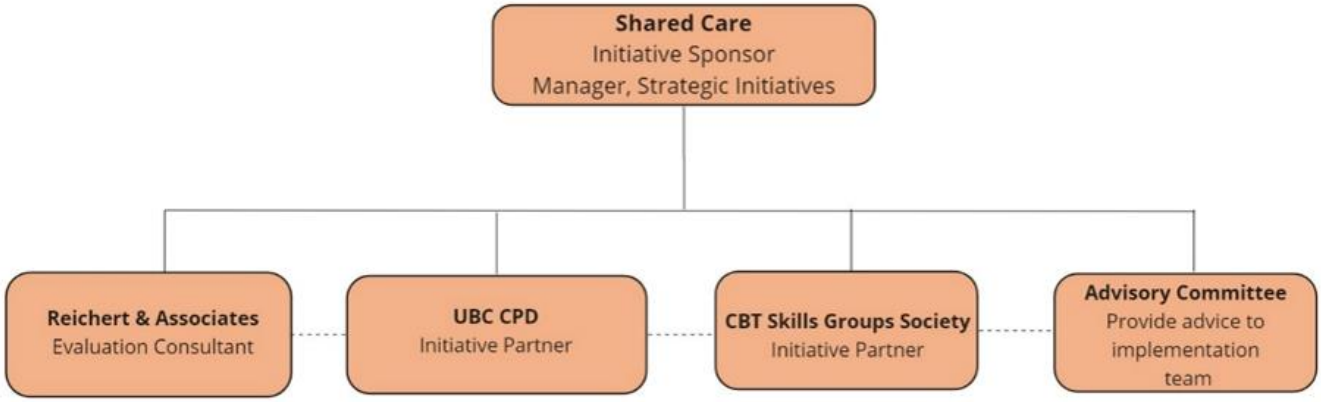
This section presents evaluation findings related to the implementation of the CBT Skills Groups Spread Initiative (the initiative). These findings are based primarily on key informant interviews with representatives from the Skills Society, Doctors of BC, UBC CPD and the Physician Health Program involved in implementing the initiative, as well as a review of documents related to the initiative and Skills Society materials (e.g., patient referral form, Skills Society website).

How was the initiative implemented?

Governance of the initiative

The initiative is sponsored by Shared Care and the leadership of the initiative is delegated to the Manager of Strategic Initiatives. The Skills Society and UBC Continuing Professional Development (UBC CPD) are partners in implementing and delivering the initiative (Figure 2). Shared Care, along with Doctors of BC and the BC Ministry of Health, funds the initiative through their Shared Care Committee (SCC).

Figure 2. Governance of the CBT Skills Groups Spread Initiative



The Skills Society offers CBT Skills Groups to patients / primary care providers and trains interested / eligible physicians to facilitate CBT Skills Groups for patients. The Skills Society also administers the patient referral process and is responsible for the overall functioning of the initiative and integrity of the CBT Skills Groups Program.

UBC CPD provides Phase 1 training to interested physicians and works closely with the Skills Society to identify physicians who are interested / eligible to proceed with training to become a CBT Skills Groups facilitator (also referred to as advanced training or Phases 2-4 of training). UBC CPD refers to their Phase 1 training as Physician Wellness training since it is intended to be available to all interested physicians, those who may want to only take training to benefit their own wellness / practice rather than proceed to advanced facilitator training. A CBT Skills Groups Training Committee, which includes representatives from the Skills Society, UBC CPD as well as CBT Skills Groups Trainers, was also established to support the initiative. This committee meets regularly to review trainee applications for advanced facilitator training and to interview and select trainees to proceed to advanced facilitator training. Decisions are based on selection criteria developed by CBT Skills Groups Training Committee and with input from Divisions of Family Practice.

Key team members from the Skills Society, UBC CPD, Doctors of BC, Shared Care, and the Vancouver Division of Family Practice, a key Division partner of the Skills Society which helped to spread the program to Vancouver, communicate regularly through leadership meetings. These meetings occur approximately every two weeks to discuss the initiative, identify and work on priorities, and to address any issues that arise.

Additional oversight for the initiative is provided through the CBT Spread Initiative Advisory Committee (Advisory Committee) which is comprised of many of the same individuals who attend the leadership meetings and includes representatives from the Skills Society, UBC CPD, Doctors of BC, the Physician Health Program, and physician representatives from the Shared Care Committee. The role of the Advisory Committee has evolved over time; however, the purpose of this group is to support the development of strategic partnerships and provide overall advice about the implementation of the spread initiative.

Preparations for the initiative

The key partners of the initiative worked together to apply for the funding, and once awarded, to develop the program model and processes. The key steps undertaken, as shared by key informant interviewees, are outlined in Table 1 below.

Table 1. Preparing for the initiative

Activity	Description
Identifying learnings from Victoria pilot CBT Skills Groups	• Identify learnings from the initial pilot project which was created in Victoria in 2015 by a group of physicians and supported by the Shared Care Committee (SCC) and the Victoria Division of Family Practice
Identifying learnings from the Vancouver Division CBT Skills Groups	• Identify learnings from the Vancouver Division of Family Practice (VDFP) CBT Skills Groups, set up by the VDFP in 2017 and run independently from the Victoria CBT Skills Groups until the establishment of the Skills Society in 2021

Deciding that Shared Care wanted CBT to be a spread project and receiving funding	• Shared Care Committee identifying that they wanted the CBT Skills Groups to become a provincial spread project, and approving funding for it • Funding from Shared Care Committee for the provincial spread was received in late 2021
Establishing Skills Society as an independent organization	• Establishing where the administrative aspects of CBT Skills Groups were going to be operating out of, whether through creating an independent organization or through the health authority • Amalgamating past data together, purchasing a server to hold the data, and creating one referral centre for the entire province of BC: the Skills Society
Identifying implementation partners and developing structures to support the team	• Identifying that the Skills Society, UBC CPD, and Doctors of BC would be directly involved in the spread initiative • Establishing leadership and governance structures (e.g., Advisory Committee, leadership meetings) as well as policies and foundational documents
Identifying external partners needed for the spread initiative	• Identifying which partners to reach out to including the Ministry of Health, health authorities, Divisions of Family Practice, and Primary Care Networks (PCNs)
Building awareness of CBT Skills Groups	• Communicating about CBT Skills Groups amongst Divisions, PCNs, health authorities, and the Ministry of Health
Building a community of facilitators	• Partnering with UBC CPD to provide physician wellness training, and identifying physicians who are interested in advanced training to become a CBT Skills Group facilitator
Piloting of the UBC CPD Physician Wellness group	• UBC CPD offered a pilot group to determine the best way to offer and run physician wellness training. This pilot took place in October 2021

A program model was also developed for the initiative which outlines the **training targets for UBC CPD and the Skills Society** (Figure 3).

Figure 3. Program model of the CBT Skills Groups Spread Initiative

What activities have been implemented?

This section highlights the key activities undertaken by UBC CPD and the Skills Society from the start of the initiative. The first UBC CPD physician wellness group began as a pilot in October 2021; therefore, **the evaluation considers October 1, 2021, to September 30, 2022, to be the first year of the initiative**[9].

Physician Wellness Activities

Including the pilot physician wellness group which began on October 7, 2021, a total of 16[10] Physician Wellness groups have been offered through UBC CPD from October 1, 2021, to September 30, 2022.

Most of these groups, which run over an 8-week period, have **one facilitator and 12 participants each**. Four of these 16 groups had two facilitators and 20-22 participants each. In total, **225 individuals have participated in Physician Wellness training through UBC CPD** (Figure 4).

23 individuals also participated in Phase 1 training through a Skills Society patient group therefore a total of **248 individuals have participated in Physician Wellness / Phase 1 Training as part of the initiative to date.** Figure 5 illustrates the growth in number of trainees as a result of the initiative.

Based on attendance data (n=188) shared by UBC CPD on the Physician Wellness groups completed up to September 30, 2022[10,11], **83% of participants are reported to have completed the training including 125 family physicians**. Fourteen participants (7%) did not attend any sessions; including two participants who withdrew from the program.

Figure 4. The majority of UBC CPD Physician Wellness participants (n=225) were trained in January to March 2022

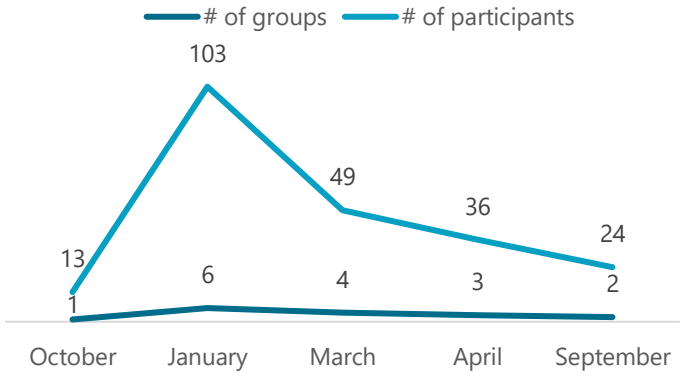
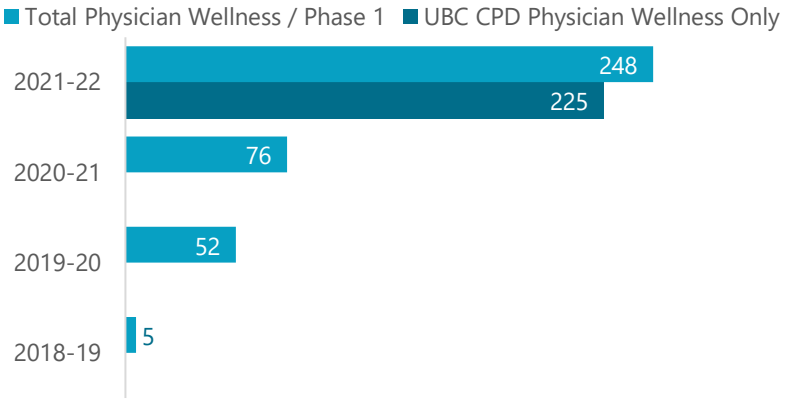


Figure 5. The number of participants in Phase 1 / Physician Wellness training have increased as a result of the initiative



Based on post program survey responses of Physician Wellness / Phase 1 participants, the main barriers to attendance were related to **scheduling conflicts**, **a health (e.g., COVID-19) or medical emergency**, a **work commitment** or **personal life commitment**. Based on the attendance data of the UBC CPD Physician Wellness groups, factors such as the date of the group (e.g., if it was in January or March), size of the group

[9] *Comparisons to prior years in this report are from comparable time periods (e.g., Oct 1, 2020, to September 30, 2021)*

[10] *2 of these 16 groups began in September 2022; sessions are still underway*

[11] *Attendance data from the Skills Society database was excluded as it appeared incomplete*

(e.g., if it had 12 or 22 participants) and number of facilitators (e.g., 1 or 2) did not appear to have an impact on attendance. Two of the groups with the lowest average attendance (on average trainees attended 5 sessions each) did however have a facilitator in common.

About the participants

Based on results from the pre program survey that is circulated by UBC CPD to those registered for Physician Wellness training, participants heard of the program primarily through **UBC CPD emails**, **a Division of Family Practice** and from **their colleagues**. Their main motivations to register for the course were primarily for their own **personal wellness**, to **better support their patients** and for **professional development / to gain skills**.

The majority of those registered for Physician Wellness / Phase 1 training are family physicians (76%; 189 of 248), followed by Specialist Physicians (17%; 43 of 248). Other registrants included Family Physician Residents (n=9) and Nurse Practitioners (n=2).

The 248 Physician Wellness / Phase 1 trainees are from health authority regions from across BC, and from 25 different Divisions of Family Practice, **the majority from Shuswap North Okanagan, Vancouver and Fraser Northwest** (Figures 6 and 7).

Figure 6. Most Physician Wellness / Phase 1 participants (n=248) are from the Vancouver Coastal Health Region

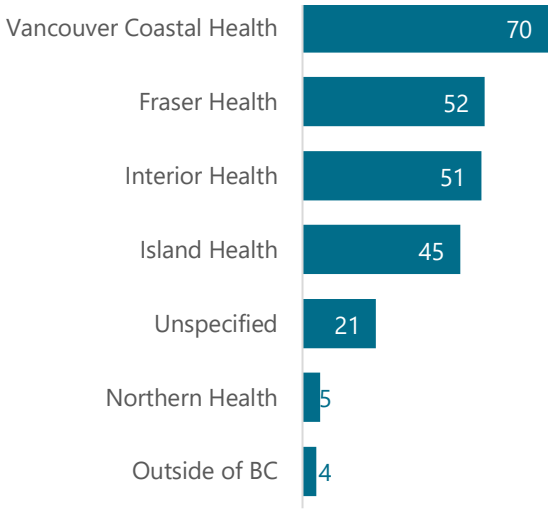
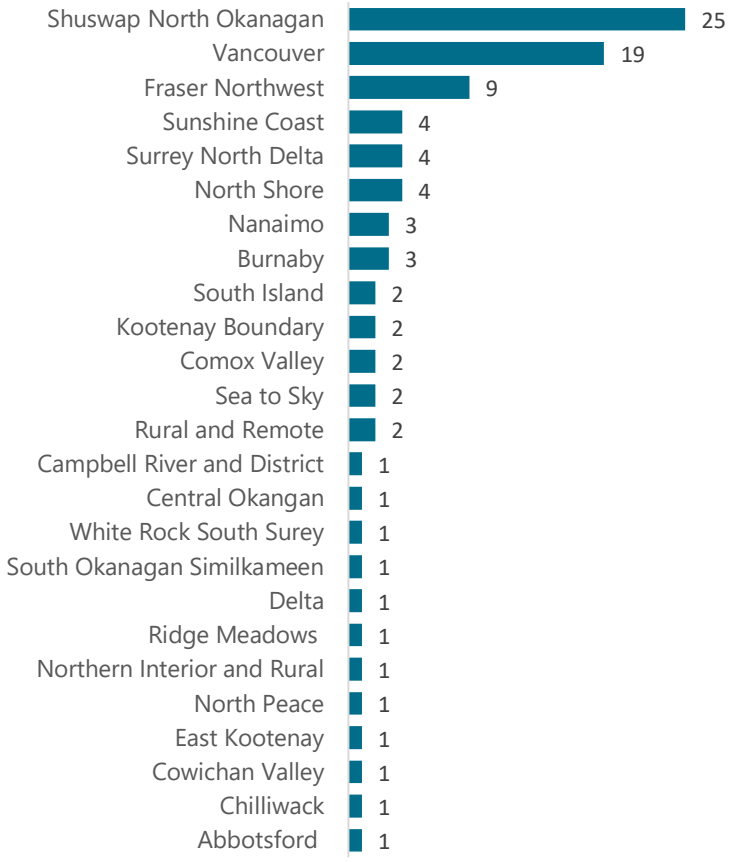


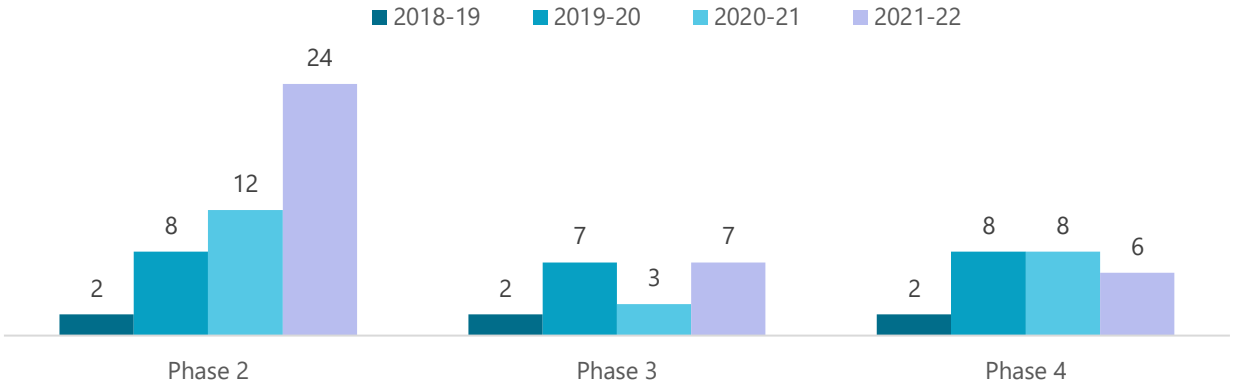
Figure 7. Breakdown of Physician Wellness / Phase 1 participants (n=248) by Division of Family Practice



Phase 2-5 Training Activities

From October 1, 2021, to September 30, 2022, there have been 24 trainees in Phase 2 training, 7 trainees in Phase 3 training and 6 trainees in Phase 4 (Figure 8). Of the family physicians currently in Phases 2-4[12] of training and based on available data from the Skills Society Access Database, **7 had participated in UBC CPD Physician Wellness training.** As illustrated in Figure 8, **the number of trainees in Phase 2 has doubled since the same time as last year** (October 1, 2020, to September 30, 2021).

Figure 8. 37 family physicians are currently in Phases 2-4 of training



Equity, Diversity and Inclusion Training Activities

Workshops focused on equity, diversity and inclusion were also made available by UBC CPD to Physician Wellness / Phase 1-5 and UBC CPD / Skills Society staff from October 1, 2021, to September 30, 2022. Principles of equity, diversity and inclusivity were also incorporated by the Skills Society into their training curriculum and facilitator guides with the goal of 1) **ensuring their program is as impactful and inclusive as possible** by reflecting the diversity of participants, 2) **minimizing possible harm** caused by facilitator or peers' blind spots and to acknowledge and repair any negative impact of their actions skillfully and 3) to recognize that we will all make mistakes and **create a culture that is curious, compassionate, and open to learning** and adapting.

UBC CPD requests workshop participants to complete an evaluation survey to assess the effectiveness of the workshops. Questions have also been incorporated into the ongoing patient and trainee surveys being leveraged for this evaluation, as well as in interview and focus group guides, to assess how the workshops are working for trainees and whether patients feel safe, welcome and respected in the groups. The results from these survey questions are presented in the following section of this report: **Experience of patients from diverse backgrounds and lived experiences.**

[12] *Phase 5 was added to the Skills Society training program in mid-2022, at the time of this report no CBT Skills Groups facilitators have started Phase 5*

Referrals to Patient CBT Skills Groups

Any primary care provider in BC can refer a patient to the CBT Skills Groups program; it is the responsibility of the patients' primary care provider to ensure the patient a good fit for the program (by reviewing the program inclusion and exclusion criteria[13] and having their patient complete the PHQ9 questionnaire). If their patient scores 18 or lower on the PHQ-9 and is not suicidal, the primary care provider submits a patient referral form[14] to the Skills Society. From October 1, 2021, to September 30, 2022, **5,882 patient referrals were received from across the province** (Figures 8 and 9).

Figure 9. The majority of referred patients (3,315 or 57%) are from the Island Health region

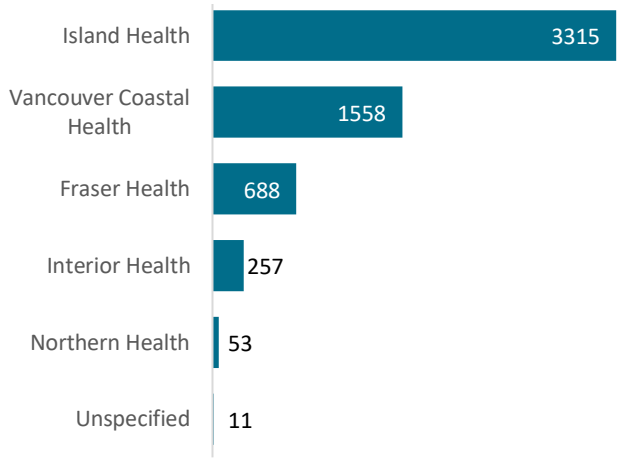
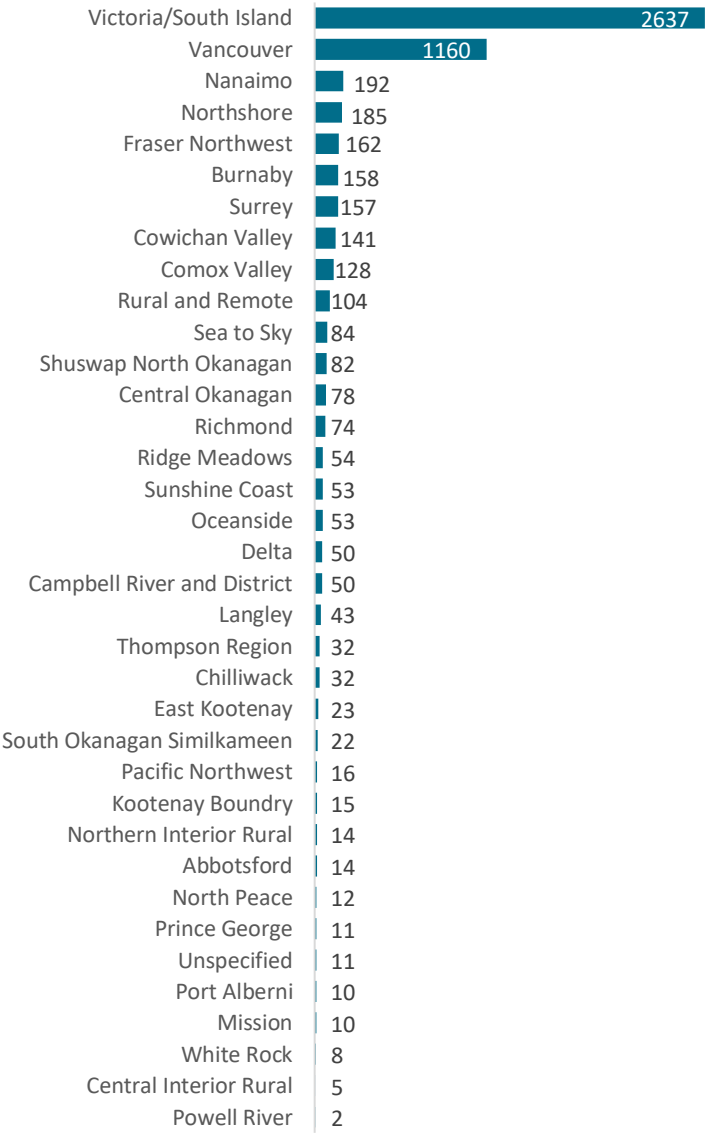


Figure 10. The majority of referred patients are referred from providers in the Victoria and South Island Divisions of Family Practice



These referrals were made by 1,486 different primary care providers. On average, primary care providers referred 4 patients each from October 1, 2021, to September 30, 2022. It is most common for a primary care provider to refer 1 patient. The highest number of referrals received from 1 primary care provider from October 1, 2021, to September 30, 2022, was 67 patients.

[13] *CBT Skills Groups Program inclusion and exclusion criteria: https://cbtskills.ca/wp-content/uploads/inclusionexclusion-referral-graphics-4.pdf, accessed December 22, 2022*

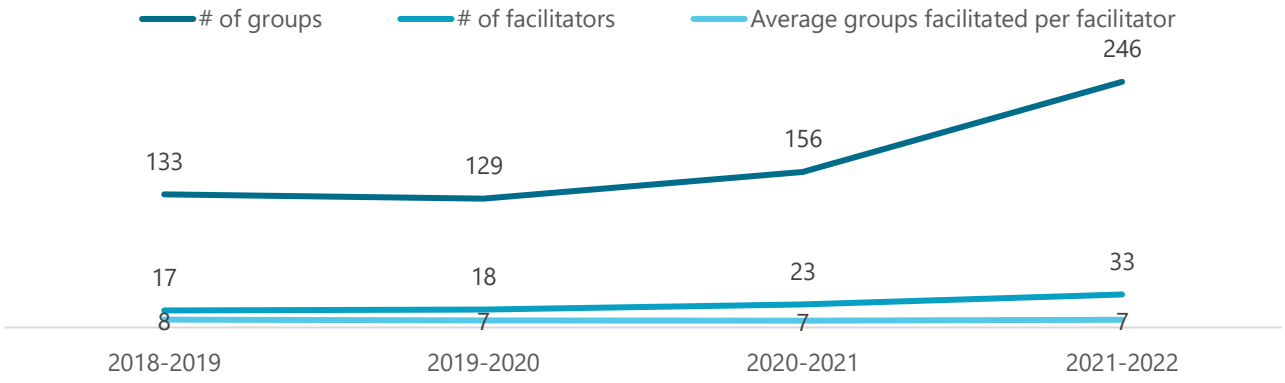
[14] *CBT Skills Groups Program patient referral form: https://cbtskills.ca/wp-content/uploads/CBT-SKILLS-GROUP-PROVINCIAL-REFERRAL-FORM-FILLABLE-2021.pdf, access December 22, 2022*

Patient CBT Skills Groups

The Skills Society has continued to offer CBT Skills Groups, facilitated by psychiatrists and / or family physicians who have successfully completed Phase 4 of training, to patients over the course of the initiative. The Skills Society offers the following groups to patients: CBT Skills Foundations (also known as Level 1), Level 2 groups for those who have completed CBT Skills Foundations and are looking to consolidate their skills and topic specific Booster groups (such as on insomnia). The patient referral form submitted by their primary care provider does not specify which type of group the patient should register for therefore **the evaluation focuses on CBT Skills Foundations, the entry level offering of CBT Skills Groups.**

A total of **246[15] CBT Skills Foundation groups were held from October 1, 2021, to September 30, 2022** (Figure 11). Figure 10 below identifies the number of groups facilitated this evaluation period (2021-2022), and how CBT Skills Foundation groups have increased over time. **The increase illustrated in Figure 11 is not attributed to the spread initiative** – it is due to additional facilitators being trained in the Comox Valley and the Rural and Remote Divisions through prior Shared Care Committee funding and due to the transition to offering patient groups online (initially in response to the COVID-19 pandemic).

Figure 11. 246 CBT Skills Foundation groups were delivered this year, a 58% increase from the same time last year

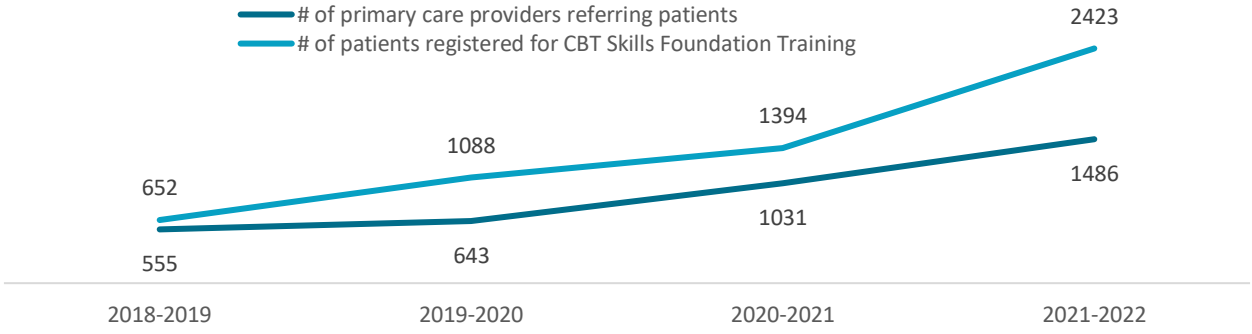


A total of 33 facilitators offered these 246 groups, which is a calculated average of 7 groups per facilitator (Figure 11). **This year, it was most common for a facilitator to run 4 groups** however 1 facilitator ran one group and another facilitator offered 39 groups. It typically takes more than a year for a family physician trainee to complete advanced training (Phases 2-4) to become a certified CBT Skills Groups facilitator, therefore no trainees from the UBC CPD Physician Wellness Program have become facilitators yet.

From October 2021 to September 30, 2022, a total of **2,423 patients from across the province were registered for a CBT Skills Foundation group** (Figure 12). Figure 11 below also illustrates how CBT Skills Foundation group registrants have increased over time, along with the number of primary care providers making these referrals.

[15] *This only includes groups that had started and ended by September 30, 2022*

Figure 12. 2,423 patients were registered for a CBT Skills Foundation group this year



Of these patients with a group completion status available (n=1,963), **77% completed the group, meaning they attended 6 or more of the 8 sessions**. 20% partially completed the group, meaning they attended less than 6 sessions, and 3% did not attend any sessions (considered a no show).

About the participants

Patients registered for a CBT Skills Foundations group from October 1, 2021, to September 30, 2022, were from across the province, primarily from the Island Health region and the Victoria and South Island Divisions of Family Practice (Figures 13 and 14).

Figure 14. 1,367 (60%) of patients registered for a CBT Skills Foundations group are from Island Health

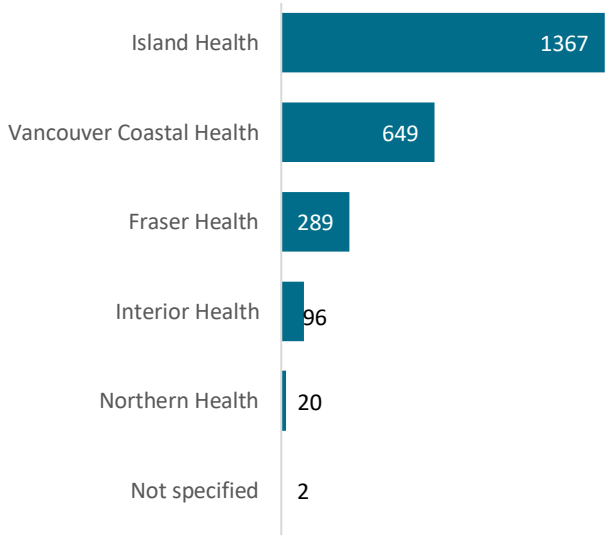
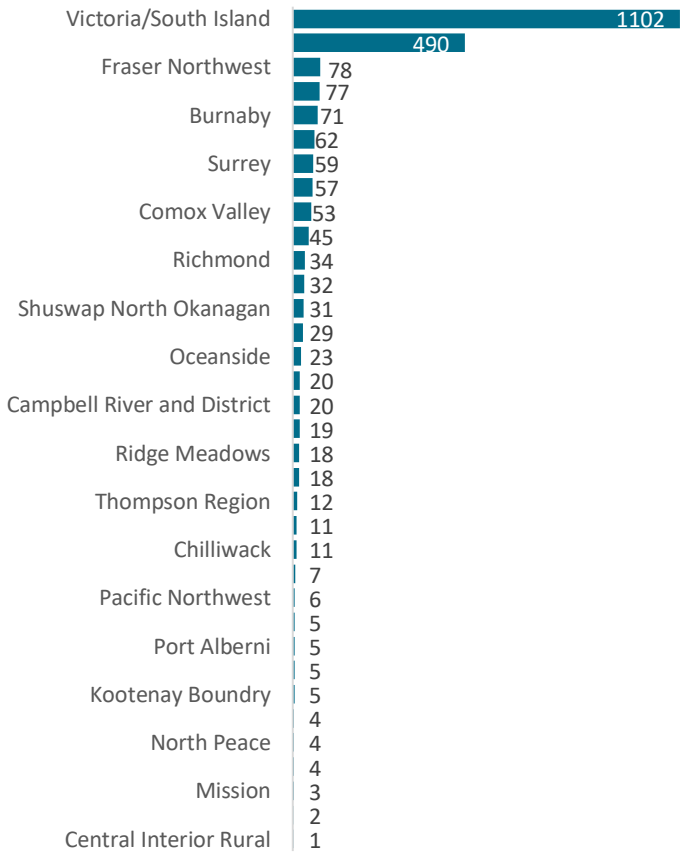


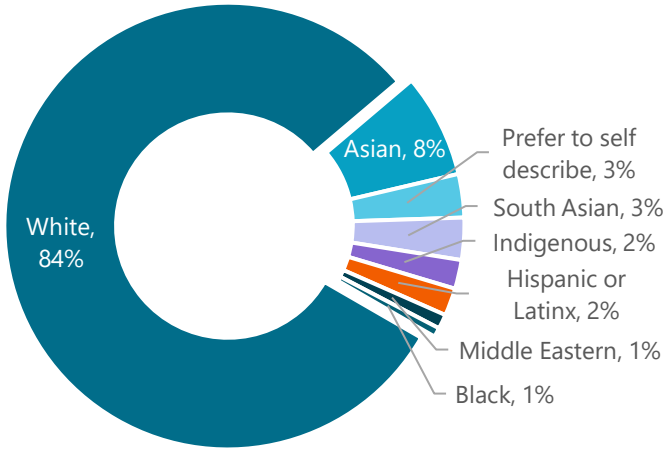
Figure 13. Most registered patients were from the Victoria and South Island Divisions of Family Practice



A pre program survey is sent to patients once they register for a group. The goal of pre program survey is to better understand the CBT Skills Groups patient population[16] since the referral form submitted by the primary care provider only includes the patients' sex, age and mental health diagnosis (PHQ-9 score and other diagnostic codes). All survey questions are optional, and respondents are informed they can skip any or all questions they do not feel comfortable answering[17].

Based on survey responses received in 2022, when the survey was created, **most patients (84%; 845 of 1008) registering for a CBT Skills Group[18] identify as white**, followed by Asian (8%), South Asian (3%), Indigenous (2%) and Hispanic or Latinx (2%) (Figure 15). 3% of patients who responded to this question preferred to self describe, primarily as Caucasian. **As for the language most spoken at home, 99% of patient survey respondents selected English** (980 of 990 respondents).

Figure 15. 84% of patient survey respondents (n=1008) identified as white



Most patient survey respondents identified as a woman (77%; 768 of 991) **or as a man** (19%; 192 of 991) **and as straight / heterosexual** (80%; 791 of 983).

Patient survey respondents were also asked to share their income bracket and employment status. Of the survey respondents who shared their income level (n=737), **the most common income level was $60,000 -$99,999, the second most common was $30,000 - $59,999 range and third most common the $100 - $129,999 range** (Figure 16).

Figure 16. 52% of pre program patient survey respondents make between $30,000 to $99,999 a year

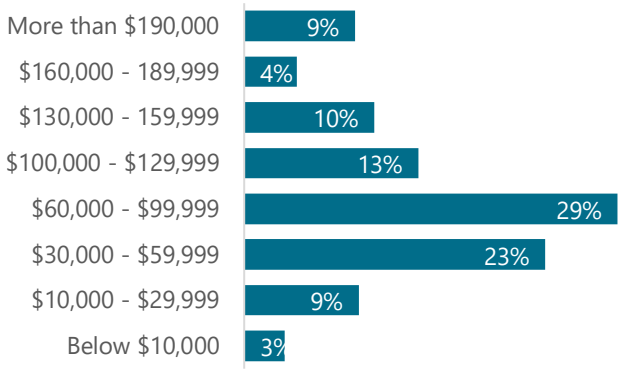
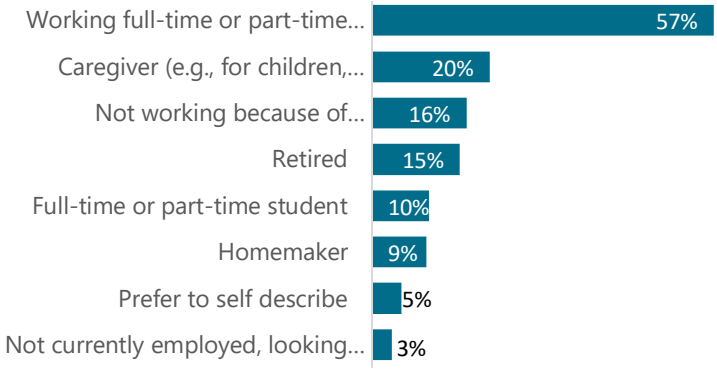


Figure 17. 57% of patient survey respondents are working full or part-time



[16] Additional analysis has not been completed to determine whether the CBT Skills Groups patient population is representative of British Columbians

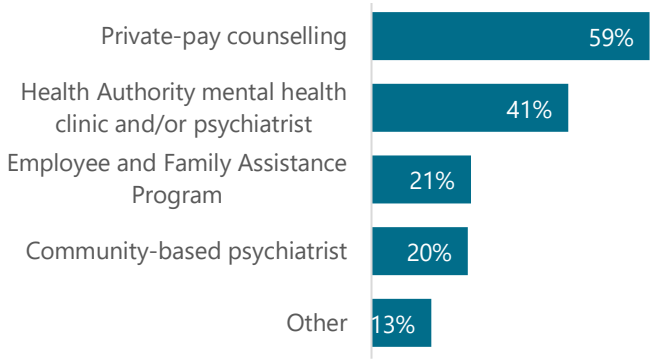
[17] For questions about race, gender and sexual orientation, respondents were able to select all that apply; survey responses may not add to 100%

[18] The group level / type of the patient was not always reported in the pre program survey, the survey data presented includes patients for any group type / level

It was most common for patient survey respondents (n=965) to be working full-time or part time (Figure 17). 15% identified as a caregiver and 12% were not working because of a permanent or temporary disability. Of those respondents who preferred to self-describe, 39% (19 of 49) described being self-employed or a contract worker, and **18% (9 of 49) described being on leave from work due to a mental health reason** (e.g., depression, stress).

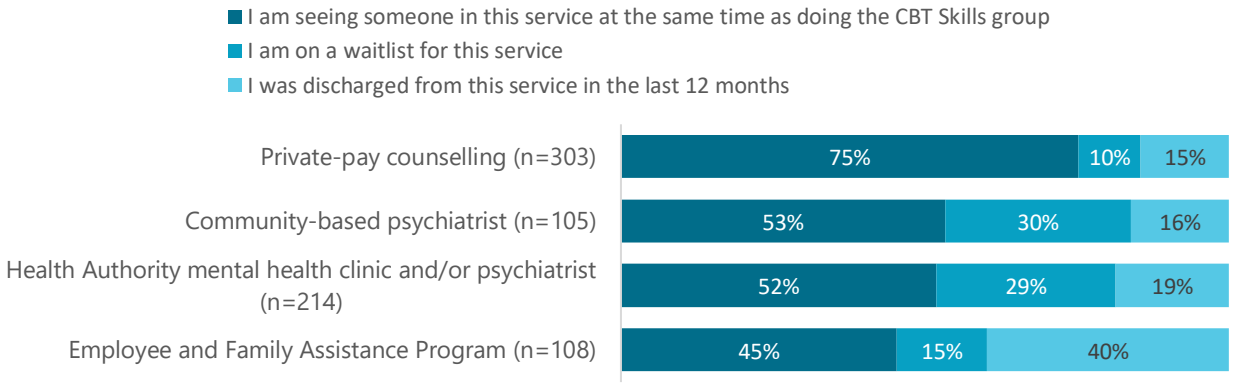
The pre program survey also asks patients about other mental health services or supports they are, plan to, or have used previously. Of pre program survey patient respondents who responded to this question (n=517)**, 59% of patients indicated private-pay counselling as a service they have used / are currently using or are on a waitlist for** and **41% have used / are currently using or are on a waitlist for a Health Authority mental health clinic and/or psychiatrist** (e.g., psychiatry outpatient department) (Figure 18).

Figure 18. 59% of pre program patient survey respondents (n=517) had, are currently or are on a waitlist for private-pay counselling



Of those who had noted private-pay counselling (n=303), 75% were accessing private-pay counselling at the same time as the CBT Skills Group (Figure 19).

Figure 19. Of patients who noted they had, are currently or are on a waitlist for private-pay counselling, 75% are using private-pay counselling at the same time as the CBT Skills group



Of those who had noted a health authority mental health service (n=214), 52% were currently accessing the service and 29% were on a waitlist (Figure 19).

To what extent has the initiative achieved its intended objectives?

Outcomes for Phase 1 / Physician Wellness Trainees

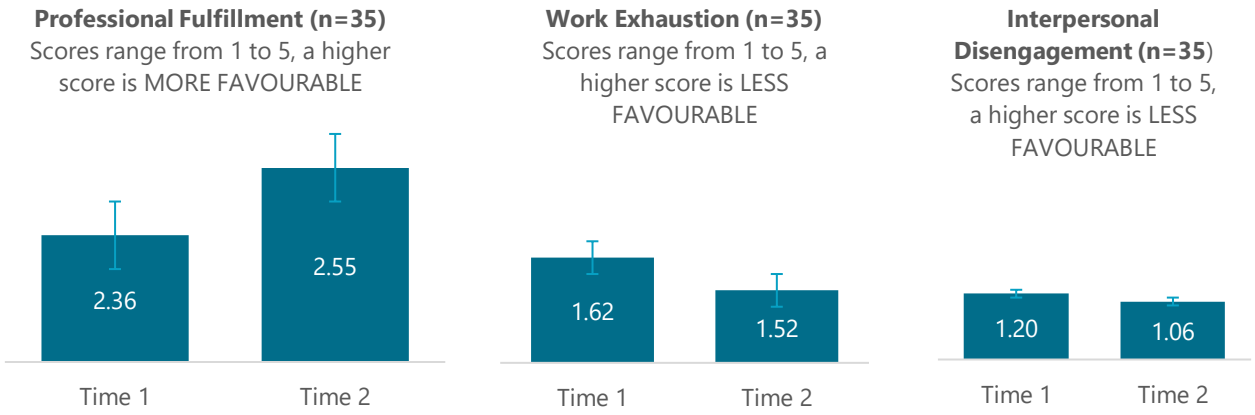
To assess impacts and outcomes of the Phase 1 / Physician Wellness training, participants were requested to complete a questionnaire at the start and end of their training which includes the Stanford Professional

Fulfilment Index (PFI) and the Brief Resilience Scale (BRS)[19] and a final evaluation survey. In future years of the evaluation, focus groups will be conducted with primary care providers who did, and did not complete the training, to gather more information on their experience. A follow-up survey is also planned for those participants who completed the training to assess any long-term impacts of the training.

Impacts on Physician Wellness

Based on available data from Physician Wellness / Phase 1 participants who completed the Professional Fulfillment Index (PFI) survey at the start and end of their training (n=35), participants experienced an **increase in professional fulfillment**, and **decreases in work exhaustion and interpersonal disengagement** (Figure 20).

Figure 20. Physician wellness / phase 1 participants (n=35) reported improvements in their professional life

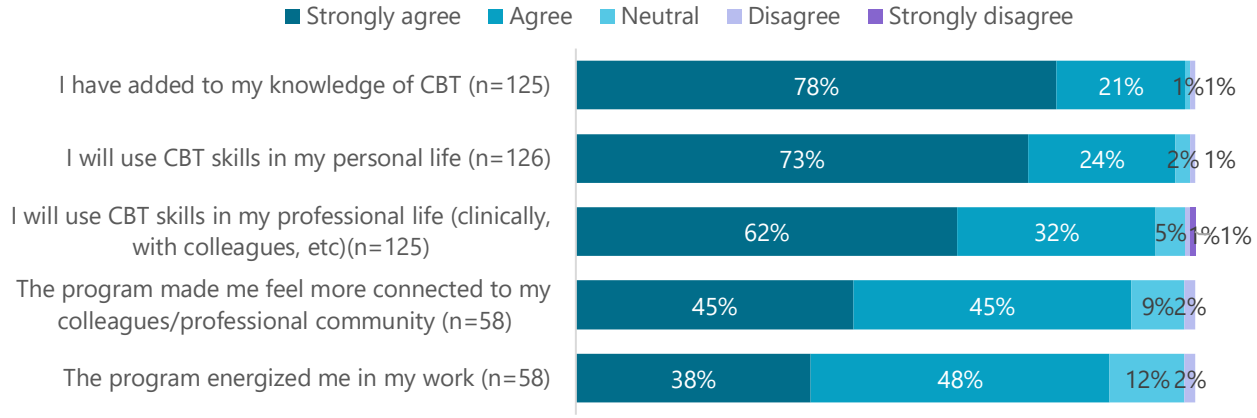


The improvement in professional fulfillment was found to be statistically significant at the 95% confidence level (p=.04). Improvements in work exhaustion and interpersonal disengagement did not meet the threshold for statistical significance (p=0.22 and 0.19, respectively). Effect sizes (which measure the magnitude of change) were in the small range for all improvements (-0.35 for professional fulfillment, 0.21 for work exhaustion and 0.22 for interpersonal disengagement).

CBT Advisory Committee interviewees similarly noted that providers were feeling more satisfied and seeing increased resiliency after participating in a CBT Skills Group. They also noted that physicians were feeling more connected with their colleagues and mentioned that the program helped them to feel less burnt out. The sense of greater connection is corroborated by Physician Wellness / Phase 1 survey respondents, who also reported coming away with an ability to apply CBT Skills in their personal life (Figure 21).

[19] *The Brief Resilience Scale was added in June 2022; due to insufficient data it has been excluded from the analysis*

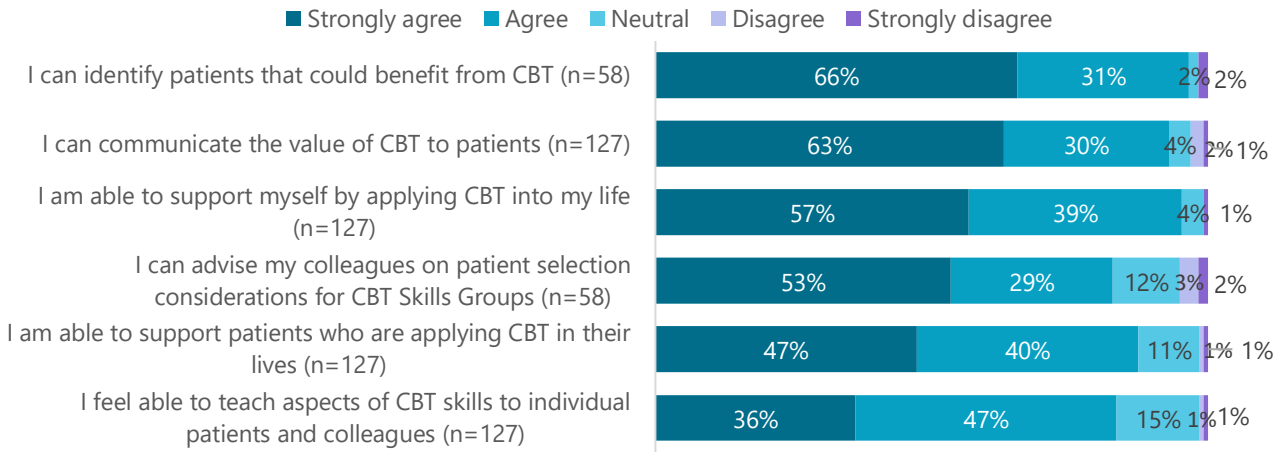
Figure 21. 98% of Physician Wellness / Phase 1 participant survey respondents have added to their knowledge of CBT



Achievement of learning outcomes

Based on responses to the post program / final evaluation survey, Physician Wellness / Phase 1 participants successfully learned about CBT Skills, who could benefit from CBT Skills and how to communicate the value of the program, both to colleagues and patients that could benefit from it (Figure 22).

Figure 22. 96% of Physician Wellness / Phase 1 survey respondents can now identify a patient that could benefit from CBT



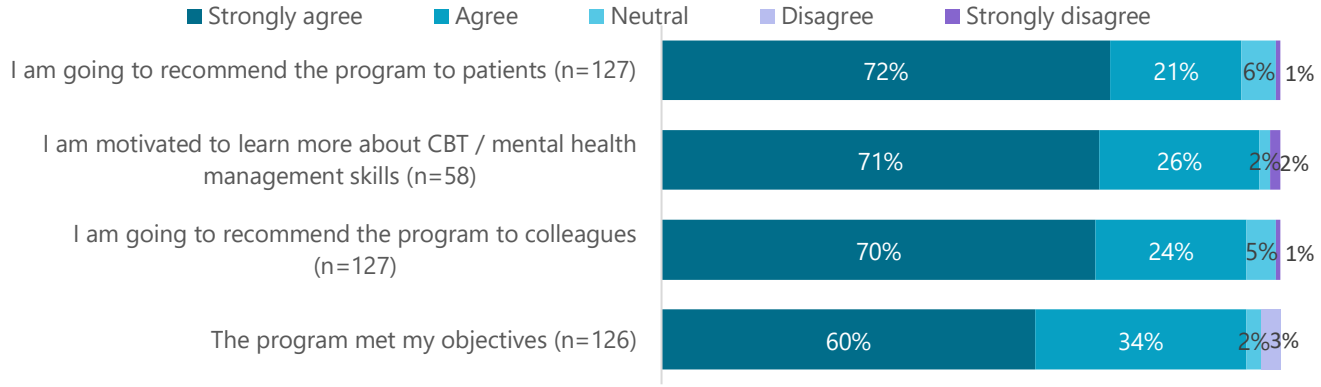
A referring provider interviewee who had also taken CBT Skills training mentioned that the CBT skills **training helps to fill a gap in soft skills for physicians, including motivational interviewing and communication skills with patients**. One CBT Advisory Committee interviewee noted an interaction with a physician who praised the impact of the CBT Skills Groups saying, ***"He's like 'That program, I enjoyed it so much. Now I know I get kind of distracted and get kerfuffled when I'm working with a patient sometimes. I go too fast. And now I can apply the STOP skill. I know I need to do it more and I'm still working on it, but that helps me so much.' Just talking about the program and how happy he is that it's available".***

> "**So much of what we do as primary care providers involves the skills that are being taught and provided through this CBT stuff**. It was for me in my practice **it just changed the way I did things and how I approached and worked with people**."
>
> *- CBT Advisory Committee interviewee*

Experience and satisfaction with the training

Based on responses to the post program / final evaluation survey, Physician Wellness / Phase 1 participants agreed the program met their objectives, and that it is a program they would recommend, to both their colleagues and to patients that could benefit from CBT Skills (Figure 23).

Figure 23. 94% of Physician Wellness / Phase 1 survey respondents would recommend the program to colleagues



The table that follows outlines what Physician Wellness / Phase 1 trainee survey respondents like best about the program and what they suggest could be improved in future:

What is working well?	What could be improved?
Knowledgeable, engaging facilitators: Physician Wellness / Phase 1 final evaluation survey respondents praised the facilitators noting that they were engaging, knowledgeable, and did a wonderful job of presenting the material. One respondent shared	**Offer different session times / different session spacing:** Physician Wellness / Phase 1 final evaluation survey respondents suggested offering groups with biweekly sessions rather than weekly sessions with one respondent noting that it could be beneficial for those with other

that, ***'The facilitator obviously was very well versed with the material and had an endless list of examples.'***

Learning and practicing new skills: Physician Wellness / Phase 1 final evaluation survey respondents most appreciated the opportunity to learn and practice new skills, specifically noting the mindfulness and grounding practices. One respondent mentioned they liked learning about the skill and the science behind it, breaking down the steps of the skills and finally getting to practice the skill during the sessions. Respondents also noted they liked building on the material that was learned in the previous week.

Engaging with other participants in the group: Physician Wellness / Phase 1 final evaluation survey respondents mentioned that they appreciated the group experience and the opportunity to practice the exercises together as a group. Respondents also mentioned they enjoyed getting to know other participants in their group, hearing about others' experiences, and having that peer connection and support. One respondent mentioned ***'I think this is a great way to learn, feel part of a community and realise that we all have our struggles in this profession.'***

responsibilities, such as co-parenting. Respondents also suggested offering varied start times to accommodate those who prefer sessions earlier or later in the evening.

Offer resources / handouts ahead of time: Physician Wellness / Phase 1 final evaluation survey respondents suggested offering resources and handouts ahead of time so that they could be reviewed prior to the session.

Encourage other participants to use the hard copy workbook: Physician Wellness / Phase 1 final evaluation survey respondents noted that it was easier for them to use the hard copy of the workbook compared to the online version and suggested to encourage others to also use the hard copy version of the workbook, where possible.

Offer check-ins/reminders in between sessions: Physician Wellness / Phase 1 final evaluation survey respondents mentioned that it could be helpful to offer check-ins with other participants or the facilitator between sessions. They also suggested offering reminders between sessions to support at-home practice. One respondent said that meeting with the same group members at another time during the week could help to foster more connection between participants.

Limit the amount of time participants share: Physician Wellness / Phase 1 final evaluation survey respondents noted that while they enjoyed connecting with other participants, at times, there was a lot of time dedicated to participants sharing their experiences. They suggested it might be valuable to limit the time for each participant to share, as it would allow for more time to be spent on the course content.

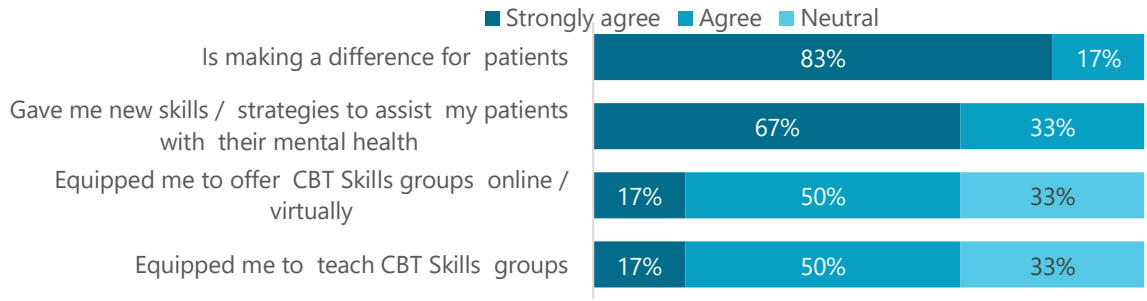
Outcomes for Phase 2-4 Trainees

To assess impacts and outcomes for Phase 2-4 trainees, participants are requested to complete competency assessment surveys at the end of each phase of training and an evaluation survey at the end of Phase 3[20]. Phase 4 participants, who co-facilitate and then solo facilitate patient groups, are also requested to report on the pre and post PHQ-8 and GAD-7 scores of the patients from their groups. The evaluation will focus only on Phase 3 survey data in this report as no trainees supported by the initiative to date have completed Phase 4. In future years of the evaluation, focus groups will be conducted with family physicians who did, and did not complete Phase 2-4 of training, to gather more information on their experience. A follow-up survey is also planned for those participants who complete Phase 4 and become facilitators to assess any long-term impacts of the training / being a facilitator.

Impacts of the training / facilitating patient groups

Based on responses to the Phase 3 evaluation survey, participants agreed the program is making a difference for patients and they felt equipped to offer and teach CBT Skills groups to patients (Figure 24).

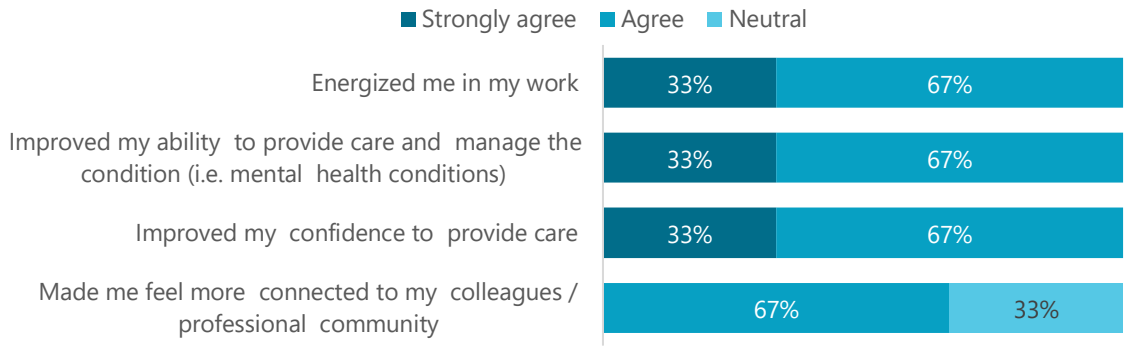
Figure 24. 67% (4 of 6) Phase 3 survey respondents agreed or strongly agreed the training equipped them with the skills to teach CBT Skills groups and make a difference for patients



Impacts on personal and / or professional life.

Based on responses to the Phase 3 evaluation survey, most respondents benefited from the training and facilitation experience, including improved confidence in providing care to their patients and being energized in their work (Figure 25).

Figure 25. 100% of Phase 3 survey respondents (6 of 6) agreed or strongly agreed the training energized them in their work

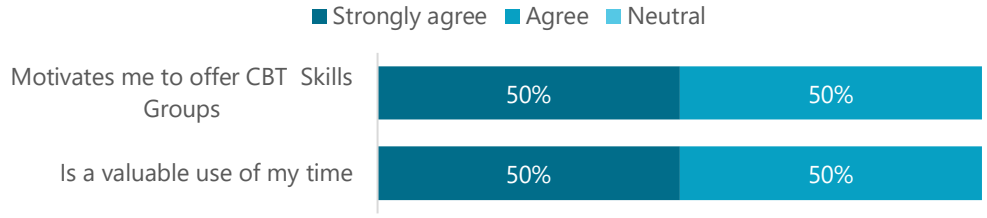


[20] *Prior to June 2022, participants were requested to complete the evaluation survey after each Phase of training*

Experience and satisfaction with the training

Based on responses to the Phase 3 evaluation survey, 100% of respondents agreed, or strongly agreed the program was a valuable use of their time and motivated them to offer CBT Skills groups (Figure 26).

Figure 26. 100% of Phase 3 survey respondents agreed the program is a valuable use of their time



The table that follows outlines what Phase 2-4 trainee survey respondents like best about the training and what they suggest could be improved in future:

What is working well?	What could be improved?
Being able to pass on skills to patients: One Phase 2-4 survey respondent mentioned the skills they are learning are helpful noting ***'[The skills] help me be able to make some recommendations to patients for things that they can do'.***	**Offer sessional payments (e.g., for prep/debrief sessions, for participating in CBT Skills Groups):** Phase 2-4 survey respondents suggested being compensated for the time it takes to prepare and be part of the CBT Skills Groups sessions. One respondent noted that they felt the debrief and preparation sessions together count for most of the time spent outside of the course and suggested that both sessions be counted together for the sessional payment. This was particularly true for urban physicians.
Building relationships with patients: One Phase 2-4 survey respondent mentioned the skills they are learning are helpful noting, ***'[The skills] help me be able to make some recommendations to patients for things that they can do'*** and another respondent enjoyed engaging more with patients, sharing that ***'Engaging with patients in a way that allows for relationship building and deeper understanding of their life circumstances. Much more rewarding than 10 minute office visits!'***	**Additional orientation prior to starting the training**: One Phase 2-4 survey respondent noted it would be valuable to have a 15-minute meeting prior to the training to go over basic features of Zoom as well as orientation to the website as they mentioned that a lot of information was sent electronically, and they would prefer not to take up session time to review orientation pieces.
	Offer hardcopy of the workbook to facilitators: One Phase 2-4 survey respondent mentioned that they would like to have a hard copy of the workbook if that was made available to facilitators.

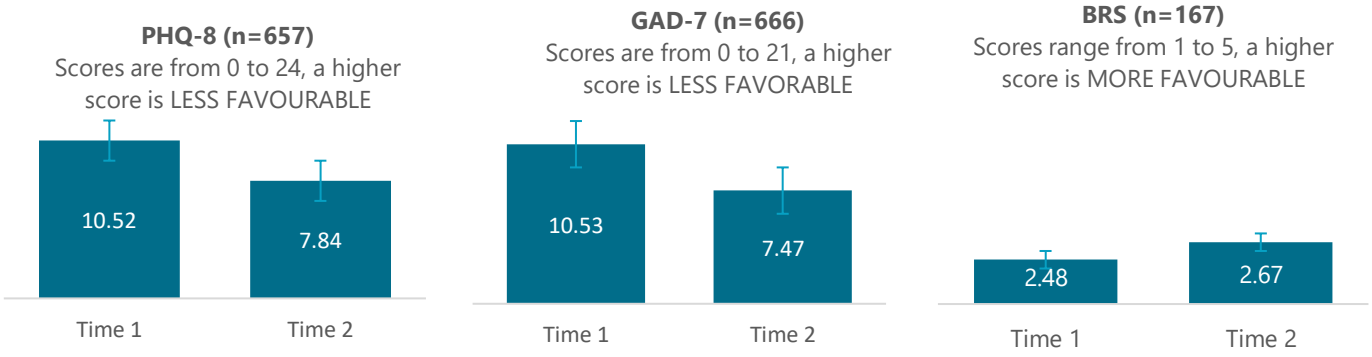
Outcomes for participating patients

To assess impacts and outcomes of the CBT Skills groups, patient participants were requested to complete a questionnaire at the start and end of their training which includes the Patient Health Questionnaire 8 (PHQ 8), the Generalized Anxiety Disorder (GAD-7) and the Brief Resilience Scale (BRS). Patient participants were also requested to complete a final evaluation survey. In addition to leveraging this existing survey data, the evaluation also conducted focus groups with patients in August / September 2022 to better understand their experience in the groups and how it may have impacted their life.

Impacts on Patient Wellness

Based on available data from patient participants who completed the pre and post program surveys, patients experienced statistically significant improvements ($p<.001$ for all outcomes) in their PHQ-8, GAD-7 and BRS scores (Figure 27). Effect sizes (which measures the magnitude of change) were in the medium range for improvements in depression and anxiety (0.61 for PHQ-8, 0.70 for GAD-7) and in the small range for improvements in resiliency (-0.34 for BRS).

Figure 27. Data from patient participants show a trend towards decreases in depression and/or anxiety and increases in resilience



> "Before I would always think 'I can't control my thoughts and behaviours' and things like that. But learning that there is that stop point where I can make the decision of how I'm going to continue moving forward and **it's so empowering to know I'm in control of that**."
>
> *-Patient focus group participant*

In the focus groups, several patients shared being better able to recognize and regulate their own thinking and behaviours. One patient mentioned that even though certain thoughts still enter their mind, they don't behave and react in the same way, noting ***'I don't spiral as much. I catch myself. And that is because of these courses'.*** Focus group participants also mentioned that they have a better understanding of the theory behind their thoughts and behaviours, and said they felt less alone. One focus group participant did note however that CBT may not be suitable for all patients and

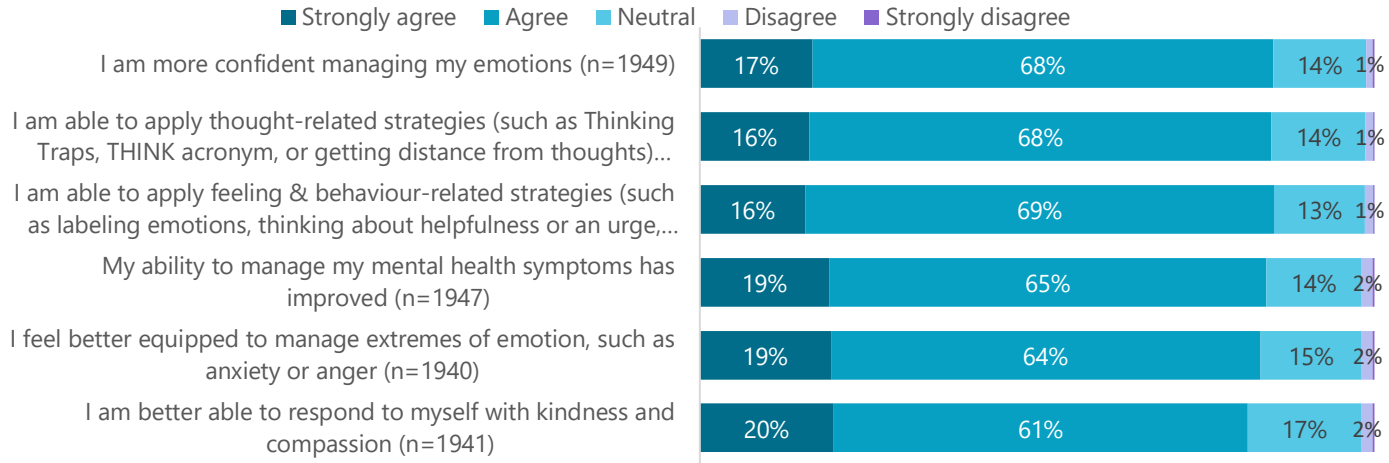
> "Helped me feel less alone, like **I was connecting with people**."
>
> *-Patient focus group participant*

suggested that warnings be provided about contraindications for CBT (e.g., mindfulness, especially without focused supports, can be destabilizing for folks with experiences of trauma).

Achievement of learning outcomes

Based on responses to the final evaluation survey, patient participants successfully gained an understanding of CBT skills and how to apply these skills in their lives (Figure 28).

Figure 28. 85% of patient final evaluation survey respondents agreed or strongly agreed they are more confident managing their emotions as a result of the group



Experience and satisfaction with the group

Based on patient responses to the final evaluation survey, **95% (2582 of 2725) of patient respondents would recommend the program to friends and family** and **94% (2529 of 2696) reported being satisfied with the CBT Skills group.**

The table that follows outlines what patient focus group and patient survey respondents like best about the groups and what they suggest could be improved in future:

What is working well?	What could be improved?
Welcoming, kind, knowledgeable facilitators: Patient final evaluation survey respondents and focus group participants noted that the facilitators were welcoming, kind, engaging, passionate, empathetic, and knowledgeable which made for a safe space. One survey respondent said ***'I appreciated that the facilitator was able to include everyone in the conversations and affirmed all the participants'*** **and one focus group participant said *'Having the instructor encourage you to open up, that kind of thing. That was really great. I think from that kind of personal side, my instructor did amazing.'***	**Increase advertising / communications about the CBT Skills Groups, including in diverse spaces:** Patient survey respondents and patient focus group participants noted that it might be valuable to increase advertising / communications about the CBT Skills Groups. One survey respondent suggested having primary care providers talk about the program with their patients or posting information about the CBT Skills Groups in their clinics. Survey respondents shared that the diversity of patients participating in the groups could be increased by advertising the groups in public and diverse

Interacting and learning with other participants in the group: Patient final evaluation survey respondents and focus group participants noted they particularly enjoyed the group learning environment and having the opportunity to interact and learn from one another. Patient focus group participants mentioned that they enjoyed learning how others in their group applied the skills, and hearing participants share examples from their own lives. One focus group participant noted ***'That tool of having that as something I could go to throughout the week and then having those exercises that I could practice on my own, and then bringing back that experience and sharing it with everybody. It felt like a really safe place to do that.'*** **One survey respondent said** ***'I had so many wonderful sharing moments. I learned from the participants as well which was an unexpected gift.'***

Easily accessible option to learn CBT skills: Final patient evaluation survey respondents and patient focus group participants appreciated that the CBT Skills Groups were offered virtually and were covered by MSP, making them an accessible, cost-effective option to learning CBT skills, and easy to fit in with existing schedules, responsibilities, and learning needs. One focus group participant said ***'I also have a physical disability and I would not have done it if it were not online. Like 100%, hard no. Even without a pandemic, it's just not possible for me to have done it'*** and another patient focus group participant noted ***'Having it by Zoom so you don't have to leave your job for a huge amount of time or carve out a huge portion of your evening is really important. And the financial accessibility of it, I think is really important. It's a pretty low cost for most people.'***

Learning new skills: Final patient evaluation survey respondents appreciated the spaces such as recreation centres or spaces where equity-seeking groups might visit.

Increase accessibility to the CBT Skills Groups for those without a family doctor: Final patient evaluation survey respondents and a patient focus group participant noted the difficulty of getting referred to the program without a family doctor with one survey respondent noting that ***'not all people have equal access to a medical practitioner who could inform them about the CBT Skills Groups'***. One respondent suggested that in addition to family doctors recommending the program, specialists could also recommend the program to their patients. Several respondents to the final patient evaluation survey and patient focus group participants **also noted that it would be valuable to offer CBT Skills Groups to young people, for example through schools**.

Increase accessibility of the workbook/resources: Final patient evaluation survey respondents suggested making sure that the workbook and resources had large and accessible text, used clear language throughout, included alt-text for diagrams and charts, and that the workbook be reviewed to ensure that it is accessible for those with vision problems. A few survey respondents also suggested offering a free or low-cost version of the workbook to make it more financially accessible.

Provide options for participants who missed sessions / want to review material: Patient focus group participants suggested offering speaking notes, audio recordings of the facilitator, or make-up sessions for participants who were unable to attend sessions. **It was also suggested that having groups on weekends and in the summer might make it easier for patients to attend sessions.**

Offer more examples / opportunities to practice skills: Respondents to the final patient evaluation survey and patient focus group

opportunity to learn practical skills they can fit into their daily lives, including how to manage stressors, noticing when they are overthinking, and resisting negative self-talk. One survey respondent said, '***I found that I often was able to help others in my immediate friend and family circle manage their own fears and anxieties by using examples and techniques that I'd learned in the CBT Skills course.'***

Developing a sense of community with other participants: Final patient evaluation survey respondents and patient focus group participants said they appreciated the sense of community that was developed with other participants in their group. They were able to relate to the other participants, have shared experiences with others, felt less alone, and that it was easy to communicate with the other participants. One focus group participant said ***'For me, the piece of it that I connected with the most, it was those times where we were personally connecting with the other people through their shared experiences in their lives. Having that connection with the other participants was probably one of the most reinforcing and valuable parts of it, I'd say'*** and a survey respondent said '***I enjoyed having such an accepting and honest group, they made me feel comfortable sharing my own thoughts'.***

Length of the Foundations course: Patient focus group participants mentioned that they appreciated the length of the Foundations course noting that 8 sessions over 8 weeks was appropriate.

participants suggested offering more examples and interactive exercises noting that sometimes it was difficult to stay focused and engaged in virtual sessions without interactive components. One patient focus group participant suggested including role-playing exercises. Survey respondents also suggested getting personalized feedback from the facilitator, and suggestions for other resources (e.g., books, videos) that participants can access to help them keep up with the skills learned.

Offer opportunities for participants to interact with each other more: Final patient evaluation survey respondents and patient focus group participants noted they would like to have more opportunities to engage with other participants both during and outside the sessions. One survey respondent suggested offering more time within the small group sessions so that participants can share their experiences. Multiple respondents expressed wanting to continue connecting with participants and one survey respondent suggested offering a reunion check-in with the group after 1 or 2 months, while a patient focus group participant suggested **developing a forum or platform where participants can stay in contact with each other.**

Clearer and more timely admin response (e.g., around how reimbursement, signing up for additional courses): Final patient evaluation survey respondents and patient focus group participants suggested to provide more clarity and more timely responses when participants had queries around how to get reimbursed, how to sign up for more courses, and being admitted into the program. Patient focus group participants also suggested **establishing a main contact person or email for participant queries** noting ***'It would be great if they had one person that was the forefront contact for everyone in the program.'***

Experience of virtual CBT Skills Groups

With the transition to virtual CBT Skills Groups as a result of the COVID-19 pandemic, patients participants were also asked in the final evaluation survey about the pros and cons of the virtual format. The key findings are highlighted in the table below:

Pros of virtual groups	Pros of in-person groups
Virtual sessions are more accessible: Final patient evaluation survey respondents and patient focus group participants most noted accessibility to be a pro of the virtual groups, appreciating they could attend the sessions from anywhere. Survey respondents without access to a car or who lived in rural areas or areas where in-person sessions are not offered appreciated the virtual option with one survey respondent noting ***'I am able to be in rural BC and still participate'***. Survey respondents also noted virtual sessions are financially accessible as there are no costs for commuting to the sessions, and survey respondents with children mentioned they were able to attend the group sessions because they did not have to arrange for childcare. **More convenient / flexible:** Several respondents to the final patient evaluation survey mentioned that they enjoyed the convenience and flexibility of attending virtual sessions noting that they were able to fit the sessions around their existing schedules and responsibilities, did not have to worry about logistics or commute time required to attend an in-person session. One respondent with uncommon work hours noted that the virtual sessions worked best for them **Virtual sessions are more comfortable and feel safer:** Final patient evaluation survey respondents noted that attending virtual sessions was more comfortable. Respondents said that they liked being in their own space as it allowed them to feel more relaxed and open up more easily. One survey respondent noted ***'Having the comfort of being in your own home, one feels more relaxed and therefore more likely to open up and discuss things***	**Better connection and engagement with the facilitator and other participants:** Final patient evaluation survey respondents noted that in-person group sessions result in better connections with other participants and the facilitator. Survey respondents also noted there was more engagement from other participants in the group with one survey respondent saying ***'I felt that the interaction was better in person. There was more open discussion and questions about the material'*** and another survey respondent saying ***'I felt I could have been more supportive and felt more supported in person. I think I could have made greater progress connecting to a group in-person'.*** **In-person sessions are less distracting:** Final patient evaluation survey respondents noted that attending the CBT Skills Groups sessions in-person was less distracting. One respondent noted that they had a hard time with length of the online sessions noting that they often lost focus, while another survey respondent mentioned that being online for the session tempted them to check their email. **In-person sessions are more comfortable:** Final patient evaluation survey respondents found the in-person groups to be less awkward, less intimidating, and they mentioned they felt less tense in the in-person groups. One survey respondent also noted they would be more comfortable talking about emotional topics in an in-person environment noting ***'Talking about myself and feelings is difficult enough without doing it to a machine'.*** **Fewer technology challenges/barriers:** Final patient evaluation survey respondents also noted the absence of tech challenges, such as poor

with the group' and another that ***'I prefer to be emotional in the privacy of my home'***. Survey respondents also noted that they liked the level of anonymity the virtual space with one respondent saying, ***'It provides added anonymity because you are in a group with people across the province rather than just your city'.***

Virtual sessions are safer during COVID-19: Final patient evaluation survey respondents said that virtual sessions felt safe given that COVID-19 continues to circulate. Respondents mentioned their tolerance for being around other people is lower because of the pandemic, and that they were not comfortable attending in-person sessions without masks. Respondents also noted that virtual sessions were also safer for their own health / medical situations with one respondent noting they were immunocompromised and that COVID continues to be a risk for them.

Virtual sessions conducive to own health / mental health needs: Final patient evaluation survey respondents and patient focus group participants also noted that the virtual sessions enabled them to still be able to attend the sessions if they had a headache or were not feeling well, which they would not have done if the sessions had been in-person. Several patients noted that virtual sessions are better due to their anxiety, with one respondent saying, ***'I already have social anxiety so in person would make it too difficult to attend'*** and another mentioning ***'As an anxious person, being able to turn the camera off during skill practice and other moments of the group helps me focus on the task at hand'.*** A patient focus group participant said ***'Sometimes, you know also, suffering from depression, there's sometimes when you're not physically able to get out of the house so it's nice to be able to still participate in something even during those times.'***

internet access or connectivity issues, as a pro of attending in-person sessions. Another survey respondent said a pro of in-person sessions was not having to navigate using technology, which is something they are not comfortable with.

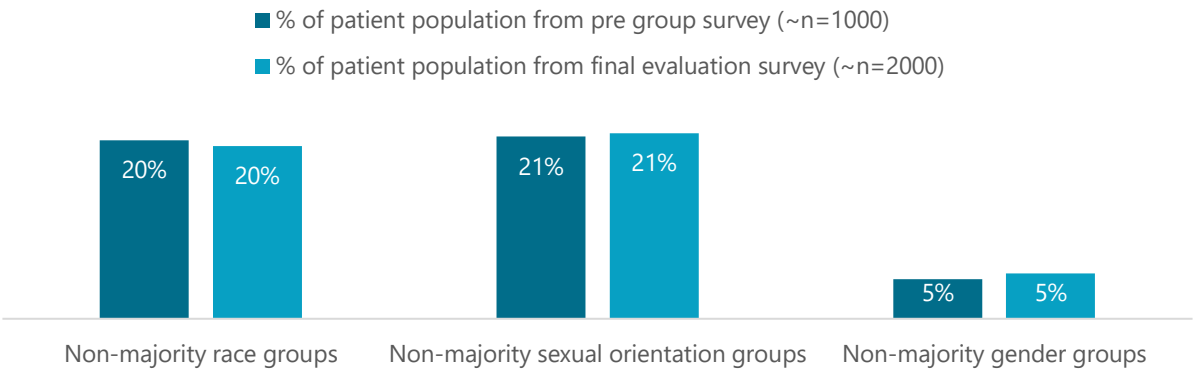
A reason to get out of the house / not be online: Final patient evaluation survey respondents noted in-person sessions gave them a reason to leave their home, particularly when they already spend a significant amount of time online (e.g., being on a computer at their jobs). Survey respondents also noted in-person sessions were helpful to combat Zoom fatigue, and one survey respondent noted a benefit for their own personal health saying, ***'With post-concussion syndrome, it is better for me not to be on a computer for so long'.***

Experience of patients from diverse backgrounds and lived experiences

The evaluation also sought to assess the experience of patients from across different backgrounds. The Skills Society Access database does not record the race, gender or sexual orientation of patients; however, this information is voluntarily collected in both the preprogram and final evaluation patient surveys. To evaluate experiences across different backgrounds and life experiences, the evaluation compared data from the majority groups of the CBT patient population to non-majority groups. This was done because some options were only identified by a small number of patients, therefore grouping different non-majority populations together provided a greater sample to analyse. For example, with regards to race, most of the CBT patient population identified as white, therefore all other races identified (Asian, South Asian, Indigenous, Hispanic or Latinx, Middle Eastern and Black) were grouped together as non-majority race groups. The evaluation team acknowledges that grouping demographics in this way does not represent the diversity across these non-majority groups; in future years once more data is available greater, more representative analysis will be possible.

Based on the proportion of demographics from the pre program survey (distributed to patients before the begin the group) and the final evaluation survey (distributed to patients who complete the group), there was no change in the proportions of patients who identified as non-majority race, sexual orientation or gender groups (Figure 29). This finding suggests that **patients from diverse background are registering for and completing the program**.

Figure 29. Patients from diverse backgrounds are registering for, and completing CBT Skills Groups



Additional cross analysis by race, gender and sexual orientation was also completed for patient final evaluation survey responses, which illustrates that **most patients across different backgrounds and experiences feel safe and welcome in the groups and would recommend the group to friends / family** (Figure 30).

Figure 30. Patients from diverse backgrounds felt welcome in the group

While the results in Figures 29 and 30 above indicate the CBT Skills Groups are working well for patients from diverse backgrounds and lived experiences, in the final patient evaluation survey patients shared several suggestions for how the CBT Skills Groups could improve in this area in future:

Suggestion	Description
Diversify the content presented in the course	Final patient evaluation survey respondents noted that it would be valuable to include content in the course about how factors such as age, race, culture, gender, sexual orientation, neurodivergence, past experiences with trauma, or socioeconomics impact mental health. One respondent who touched on the experience of being neurodivergent and practicing CBT noted '***Acknowledging this even briefly I think would help people with cognitive differences feel seen, and serve to educate others in the group to have more compassion and awareness of those challenges'.*** Final patient evaluation survey respondents and a patient focus group participant also suggested to modify some of the course content such as bringing an Indigenous and feminist lens to the content. Survey respondents also highlighted being mindful when offering examples and suggested including examples that were meaningful and representative of diverse groups (e.g., including more non-hetero relationships in the examples, and stories with not just Anglo-Saxon names)
Encourage participants and facilitators to display their pronouns with their screen name	Final patient evaluation survey respondents and a patient focus group participant suggested encouraging participants and facilitators to display and use their pronouns in their screen name. Survey respondents also suggested explaining the purpose behind and including instructions

	for how to include pronouns in their screen name and consistently doing so during each session as the use of pronouns would help others in the group be mindful of how other participants and facilitators prefer to be addressed.
Start sessions with a land/territory acknowledgment	Final patient evaluation survey respondents noted it would be valuable to state a land/territory acknowledgement of where the CBT Skills Group is based. Survey respondents also suggested explaining the purpose of land acknowledgement with one survey respondent saying '***A land acknowledgment during the class verbally, would be valuable, in terms of the impact colonialism on indigenous clients'.***
Establish, enforce, and explain reasoning for group rules to create a safe group space	Respondents to the final patient evaluation survey noted it would be valuable to state and explain ground rules, and rules for the breakout sessions, during each session as well as enforcing them as the sessions progress. One survey respondent noted it was difficult to hear other participants being spoken over during the breakout rooms and noted that this may not have happened in the larger group setting as there was appropriate moderation of the discussion.
Train facilitators on digital racism and microaggressions	Final patient evaluation survey respondents suggested additional facilitator training on digital racism and microaggressions. A survey respondent mentioned the issues around digital blackface and noted that solely using the yellow emojis could delegitimize participants' identities. A focus group participant noted an experience where the facilitator struggle to correctly pronounce their name, and a survey respondent said '***I noticed that a facilitator struggled with non-English names and would just avoid calling upon students with "uncommon" names'***. They suggested to clarify name pronunciations by the end of the first class noting that facilitators could reach out by email to clarify pronunciation and suggested training around how to navigate the aforementioned situations.
Increasing physical accessibility of the classes	One survey respondent suggested that offering modifications for the physical relaxation activities noting that some of the exercises could be challenging for those with physical disabilities. Another survey respondent suggested offering pre-recorded sessions noting ***'If the content of each chapter was pre-recorded as a lesson to be watched/studied during the week prior to each group session, I think for someone like me who has major concentration struggles and reading as a challenge, this above mentioned possibility would be really helpful'.***
Offer CBT Skills Groups sessions facilitated by diverse facilitators	Final patient evaluation survey respondents noted that while the current facilitators do an amazing job, it would be valuable to offer CBT Skills Groups hosted by facilitators with diverse lived experiences. Speaking about the possibility of offering groups led by BIPOC facilitators, one respondent said ***'While I do feel there is value in being in group with everyone from all backgrounds, that doesn't change that there are areas of life that are heavily impacted by systemic and societal biases that lead to severe anxiety and depression and to have***

	facilitators who are not only educated, but actually have lived experiences and are actively working on anti-oppression could be amazing for CBT'.
Offer groups for specific populations / topics	Final patient evaluation survey mentioned that hosting groups for specific populations, such as those who identify as women, 2SLGBTQ+, or Indigenous, might be valuable to increase safe spaces for members of these communities. One respondent noted ***'It would be nice to have an Indigenous group and facilitator. I would feel more comfortable as I do in all spaces with more Indigenous people.'*** Several final patient evaluation survey respondents noted that they would like to see additional session topics added including around ADHD, autism, neurodiversity, trauma, dissociation, narcissistic personal traits, shame, privilege, and relationships.

Outcomes for Referring Providers

As part the evaluation, a survey has been distributed to primary care providers who have referred patients to the CBT Skills groups. The responses included in this report are from primary care providers from the Vancouver Division of Family Practice; the survey will continue to collect responses from primary care providers from across the province over the next year. In addition to this survey data, four primary care providers who regularly refer patients to CBT Skills groups were interviewed.

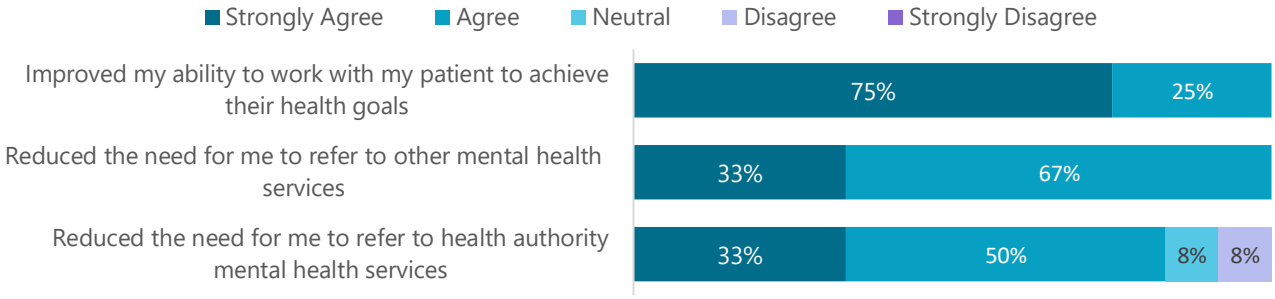
Impacts on their practice

Of referring provider survey respondents, **the majority (73%) have referred more than 10 patients to CBT Skills groups** (2 respondents selected 'I don't know' meaning they did not know how many patients they have referred) **and that of the patients they have referred, most go on to participate in a CBT Skills Group** (attend some or all the sessions). Referring provider survey respondents (n=16) most heard about the CBT Skills Groups program through their Division of Family Practice (71%), by participating in a CBT Skills Group (21%), by participating in CBT Skills Groups Facilitator Training (21%), or through a colleague (21%) (respondents able to select all that apply).

Almost all referring provider survey respondents who had referred patients to the CBT Skills program (11 of 12[21]) reported that the program was valuable or very valuable to their practice. They further agreed or strongly agreed that being able to refer to the CBT Skills program has not only improved their ability to work with their patients to achieve their health goals, but also reduced their need to refer to other mental health services (Figure 30).

[21] 4 referring provider survey respondents had not referred any patients and were not asked this question

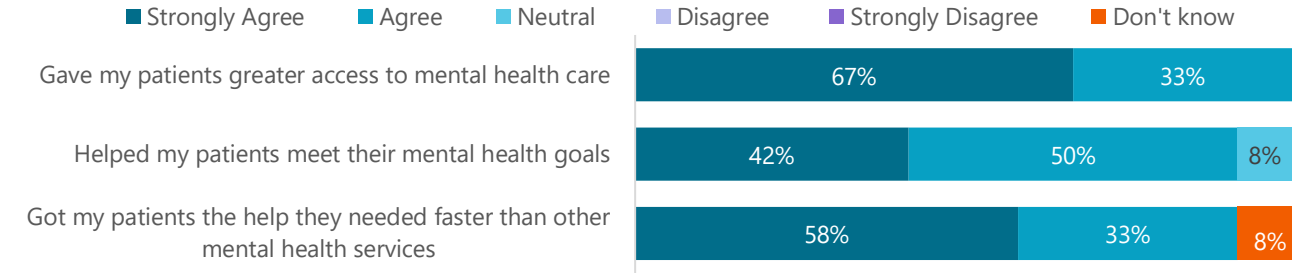
Figure 31. 100% (12 of 12) referring provider survey respondents reported the CBT Skills Groups program has improved their ability to work with patients



Access to mental health care

Referring provider survey respondents agreed, or strongly agreed that the CBT Skills Groups program gave their patients greater access to mental health care and helped their patients meet their mental health goals. Almost all survey respondents agreed that their patients got the help they needed faster than with other mental health services (Figure 32).

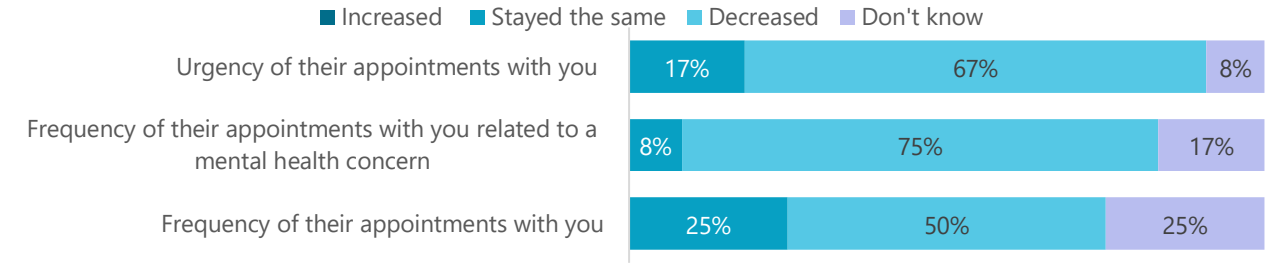
Figure 32. 100% of referring provider survey respondents agreed or strongly agreed the program gave their patients greater access to mental health care



Impacts on their patients / interactions with patients

Referring provider survey respondents were also asked to reflect on what, if any changes they have noticed in terms of their interactions with patients who have participated in a CBT Skills Groups. **The majority of referring providers survey respondents shared that they had noticed a decrease in both the urgency of their appointments with this patient and a decrease in the frequency of their appointments related to a mental health concern** (Figure 33).

Figure 33. 67% of referring provider survey respondents noticed a decrease in the urgency of appointments with patients who participated in a CBT Skills Group



Two of the four referring provider interviewees also reported seeing a decrease in the number of mental health related appointments or visits with patients they have referred.

Referring provider survey respondents also highlighted that the patients they have referred gained better coping skills. One referring provider noted that their patient had fewer 'physical or somatic complaints' and that the program **"Allowed them to use CBT skills to challenge their own thoughts and get procedures done that they otherwise would have avoided".**

Referring provider interviewees also shared seeing similar changes for their patients, including noticing emotional and mental health benefits, gaining more tools and knowledge for managing their mental health. Two of the four interviewees also shared **their patients were better able to connect with others** as a result of the program – a referring provider survey respondent also shared that **their patient was more open to group-based services after having participated in the program.**

Experience and satisfaction with the program

All referring provider survey respondents who had referred patients (n=12) reported **they are confident or very confident they can screen and select patients that could benefit from CBT Skills Groups**. Furthermore, all 12 respondents were **satisfied or very satisfied with the process of referring patients** to the CBT Skills program and 10 of the 12 respondents (**83%) would recommend the CBT Skills Groups to other primary care providers for their patients.**

The table that follows outlines what referring provider interviewees and survey respondents like best about the groups and what they suggest could be improved in future

What is working well?	What could be improved?
Access to affordable mental health supports: Referring provider survey respondents and referring provider interviewees identified that the CBT Skills Groups are an affordable and accessible mental health service. One survey respondent noted that it was easy for patients to get into the program with minimal wait times. Survey respondents noted that the CBT Skills Groups fill a gap in mental health care in BC with one survey respondent noting **'It is one of the few mental health improvements in our system that is actually working. It is incredibly cost effective'** **Seeing improvements in patients:** Through interviews with referring providers, they noted that they were seeing benefits for their patients both emotionally and mentally. Referring providers specified their patients were in a better state of mind / headspace, were able to let things go more, saw a greater sense of	**Increased communication with Skills Society including more updates / feedback about referred patients:** One referring provider survey respondent suggested it would be helpful to have more feedback about what the patient liked or did not like about the group. In interviews with referring providers, referring providers noted that they appreciated seeing the summaries after the sessions outlining patient participation levels, however, one interviewee suggested that it would be helpful to have additional information from the CBT Skills Groups admin team about when the next round of courses will be offered, and information about the time between referrals and when their patients are first contacted. **Offer additional course topics / courses in other languages:** Referring provider survey respondents suggested offering topics around ADHD, disordered eating, insomnia, and dialectical therapy. They also suggested offering

agency, and were more hopeful. One referring provider interviewee mentioned that their patient was able to use language they learned through the CBT Skills Groups to express their experiences.

Patients are guided through learning about CBT skills: In interviews with referring providers, two interviewees noted that they appreciated that patients were guided through the program and content by a facilitator. One referring provider interviewee said **'Having [the content] delivered with a physician or provider who is experienced, who is trained, and being able to share experiences with other patients who are struggling as well has been beneficial for many of my patients who feel they're often alone in their journey.'** Referring providers also noted that the accountability and encouragement of being in a group setting was valuable.

Patients able to connect with others: Referring provider interviewees mentioned the value there was for patients to connect with others in a group setting. One referring provider interviewee shared a story about their patient saying, **'Two people [group members] piped up and said, 'I feel exactly the same way, thank you for sharing that'. She said to me after that she knew that this was truly beneficial, and she was just so thankful to be part of this group.'**

Patients can learn about CBT skills in a safe, trauma-informed space: Referring provider interviewees appreciated the supportive environment for their patients to learn about CBT skills. On speaking about what a patient had said about their experience in the group, one referring provider interviewee said **'The facilitator always gave them a way out. [The facilitator] always said 'If you don't feel like sharing, it's okay. You can just pass, or just not say anything'.'**

gender-specific groups, and groups for teenagers. One referring provider interviewee also noted that it would be valuable to offer the sessions in additional languages.

Shorten/simplify the workbook: One referring provider survey respondent suggested simplifying and shortening the workbook noting that it can be challenging for someone with ADHD-like tendencies or lower literacy. They also suggested including additional side-bars and examples throughout.

Offer a concentrated version of the course: One referring provider survey respondent identified that it may be challenging for patients to make time in their schedules to attend a weekly session over 8 weeks and suggested to offer a concentrated course offering, perhaps 2 hours a week for 4 weeks or a concentrated 1-day program.

Offer follow up sessions (e.g., to refresh skills): One referring provider survey respondent identified that it might be worthwhile to offer follow-up meetings for participants after 2-4 months to solidify and refresh the skills that were learned.

Offer option to audit courses: One referring provider survey respondent suggested being able to audit the different courses.

Easy to refer patients: Referring provider interviews all noted that the referral process works well noting that the referral form is simple, and they like being able to arrange the referral directly with their patients. One referring provider interviewee noted **'The referral form is pretty simple, like there's not much to it. I'm happy with that. I don't find it onerous to complete the referral form for this program.'**

Outcomes for the wider BC health care system

Based on the data collected for the evaluation to date, including the findings highlighted from both patients who have participated in a CBT Skills group and the primary care providers referring these patients, the CBT Skills Group program is having a positive impact on the wider health care system in BC.

Increased access to mental health care

Both **referring provider and patient participant survey respondents agreed that the program has given patients greater access to mental health services**. One referring provider interviewee noted that the CBT Skills Groups offers access to mental health supports for patients in communities who may not have had access previously. Another referring provider interviewee mentioned that the CBT Skills Groups tries not to have bottlenecks with referrals noting that 'the family physicians can just refer, and then people don't get reassessed or held in waiting until they're assessed again'.

As highlighted in Figure 17, patients registered for a CBT Skills Group are using other mental health and many are on a waitlist for mental health services, such as to see a private-pay counsellor or to access health authority mental health services. Referring provider interviews also corroborated this. These findings indicate that the **CBT Skills Groups offer access to mental health services for patients who may be experiencing delays in accessing the care they need elsewhere**. While not a replacement for other mental health services, the CBT Skills Groups program has been found to positively impact both depression and anxiety symptoms, while helping patients to feel less isolated and alone and empowering them with new skills and tools.

CBT Advisory Committee interviewees also noted the benefits of giving primary care provider a place to refer patients with mild to moderate mental health needs, noting that family physicians may not have the capacity, skills, or fee codes to meet the mental health needs of their patients. One interviewee said, **"Regularly I hear from trainees or physicians in new communities who are like 'Wow, this is so amazing. I'm so glad to be able to refer to this'."**

> "I think it's set up really well that they have the capacity to include patients once they are referred. I think its only a two week wait time and for our current health system that is unheard of, that you can access a program in that short of period of time."
>
> *- CBT Advisory Committee interviewee*

More timely access to mental health care

In addition to having greater access to mental health services, 91% of referring provider survey respondents reported that the CBT Skills Groups programs gives their patient the help they need faster than other mental health services.

Reduced need to refer to health authority mental health services

While patients registered for CBT Skills groups may be accessing or on a waitlist for health authority mental health services, 83% of referring provider survey respondents reported that **having access to the CBT Skills Groups program has reduced their need to refer to health authority mental health services**.

Reduced and more productive appointments for primary care providers

As highlighted in Figure 31, **75% of referring provider survey respondents reported a decrease in the frequency of mental health related appointments with patients who have participated in a CBT Skills group**. 67% of referring provider respondents also reported a decrease in the urgency of these appointments. Coupled with findings from the patient participant evaluation survey, where 95% agreed they are better able to manage their symptoms, this finding suggests that **the CBT Skills Program is both supporting patients to improve their mental health while also freeing up providers' time.** Furthermore, 100% of referring provider survey respondents also agreed that the CBT Skills program improved their ability to work with their patients to achieve their health goals, which suggests that **in addition to potential time savings, they, and their patients, are getting more out of the appointments they do have.**

Increased skills, professional fulfillment and sense of community for physicians

In addition to positively impacting referring providers and their patients, **the Physician Wellness / Phase 1 training offered through the initiative has also been found to contribute to greater professional fulfillment while decreasing work exhaustion and interpersonal disengagement** (see Figure 18). Furthermore, the majority of Physician Wellness / Phase 1 and Phase 2-4 participant survey respondents have agreed that **the CBT Skills Groups program has helped to energize them in their work** and **feel more connected to their colleague and professional community.** The CBT Skills they have learned are also giving them **more tools to use with their patients and are helping to increase both their confidence and ability to manage patients' mental health conditions**.

To what extent has the integrity of CBT Skills Groups been maintained?

The success and effectiveness of the CBT Skills Groups program in terms of being able to train family physicians to deliver CBT Skills groups and achieve positive outcomes for patients has been researched and documented in peer-reviewed academic journals[22,23]. As highlighted in this report, the CBT Skills Groups has grown considerably over the past few years, in part due to the spread initiative and as a result of the

[22] *Cheek, J., Burrell, E., Tomori, C. (2019). Self-management training in cognitive-behavioural therapy skills: A project to address unmet mental health needs in Victoria, BC. BC Medical Journal, 61(8), 326-323. Accessed Dec. 21, 2022 from https://bcmj.org/articles/self-management-training-cognitive-behavioral-therapy-skills-project-address-unmet-mental*

[23] *Maheshwari, O., Burrell, E., Tomori, C., Phillip, A., Eadie, H., Kotler, M, Cheek, J. (2022). Effectiveness and accessibility of virtual Cognitive Behavioural Therapy Skills Group medical visits during COVID-19. BC Medical Journal (64)9, 383-389. Accessed Dec. 21, 2022 from https://bcmj.org/articles/effectiveness-and-accessibility-virtual-cognitive-behavioural-therapy-skills-group-medical*

transition to offering groups online as a result of the COVID-19 pandemic. To ensure that the program is continuing to achieve positive outcomes and a high level of patient, provider, trainee and facilitator satisfaction, the evaluation developed a set of key performance indicators to assess the programs' ongoing performance.

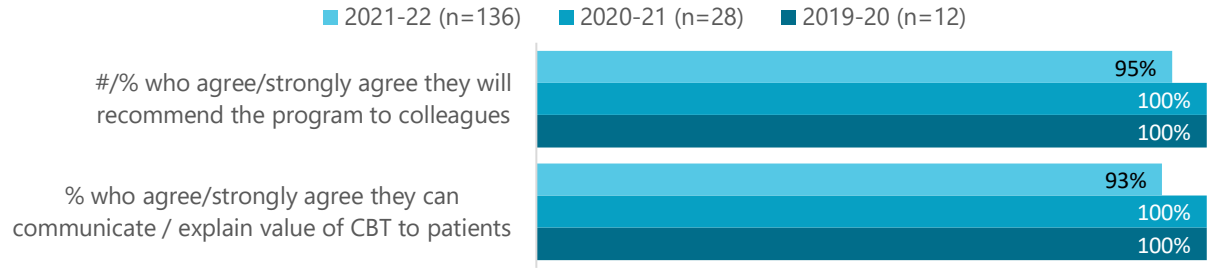
Based on available data, a total of 33 performance indicators were assessed by the evaluation this year (Appendix A). Each indicator was assessed year over year, starting from October 1, 2018, until September 30, 2022. This time frame was selected to match the start date of the initiative (starting with the first Physician Wellness pilot group starting October 2021) and to gather data from before the CBT Skills Groups program was transitioned online in 2020.

Overall, these indicators suggest that the integrity of the CBT Skills Groups program has been maintained over the first year of the initiative.

Phase 1 / Physician Wellness Trainees

Based on the historical survey data reviewed, Phase 1 / Physician Wellness trainees continue to report they are achieving their intended learning outcomes and that they would recommend the training to others (Figure 34).

Figure 34. 95% of Physician Wellness / Phase 1 trainees would recommend the program to colleague

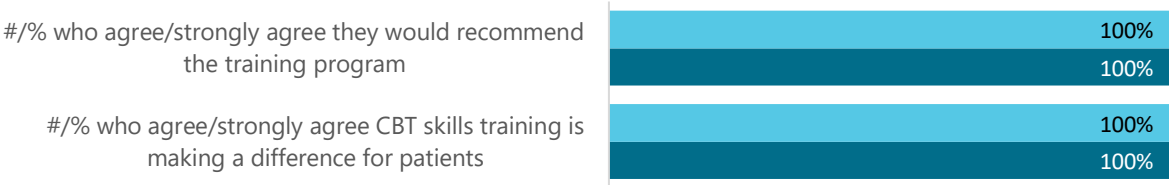


One indicator reviewed was a survey question asking whether Phase 1 / Physician Wellness trainees agree they would use CBT skills in their professional life / in their own practice. In prior years, 100% of Phase 1 / Physician Wellness survey respondents agreed with this statement. This year, however, only 66% of Phase 1 / Physician Wellness survey respondents agreed. Most survey respondents this year were those that participated in UBC CPD Physician Wellness, which is more focused on personal wellness. This finding will be monitored in future years of the evaluation.

Phase 2-4 Trainees

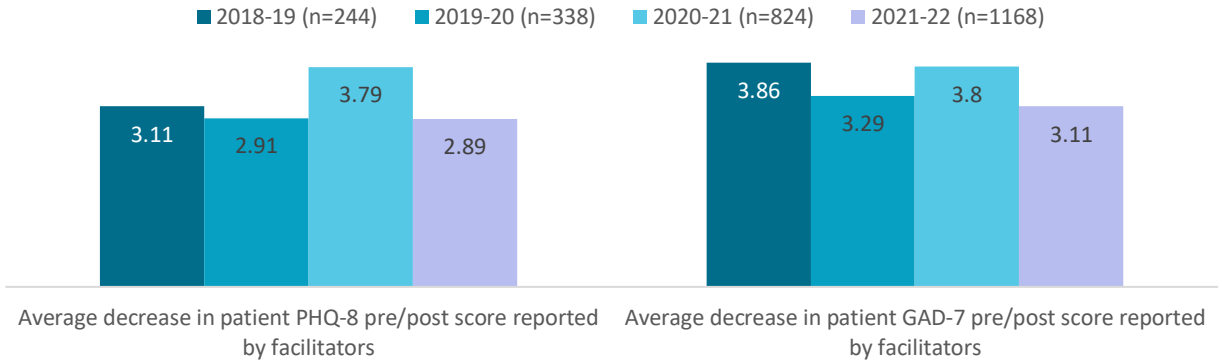
Based on the historical survey data reviewed, Phase 2-4 trainees continue to report the training is positively impacting patients and that they would recommend the training to others (Figure 35).

Figure 35. 100% of Phase 2-4 trainees would recommend the training program



Based on the pre and post program scores facilitators report for patients in their groups[24], facilitators are continuing to see decreases in the PHQ-8 and GAD-7 scores. The level of decrease has remained stable and reliable over the past 4 years (Figure 36).

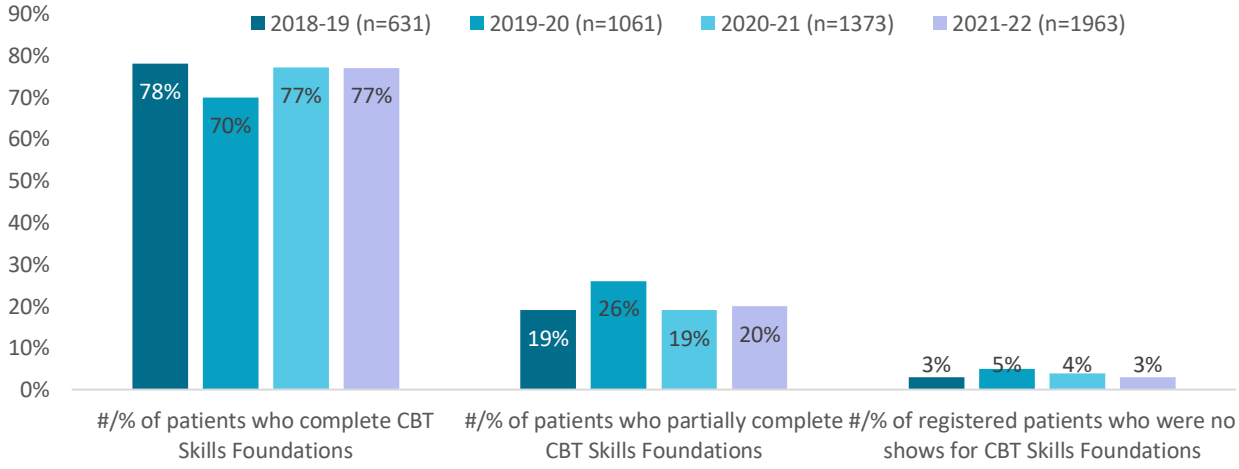
Figure 36. Facilitators continue to report comparable decreases in PHQ-8 and GAD-7 scores



Integrity of the patient groups

Based on the historical data reviewed from the Skills Society Access database, about 70% or more of patients continue to complete their CBT Skills Foundations group, and just under 5% are a no-show, attending 0 sessions (Figure 37).

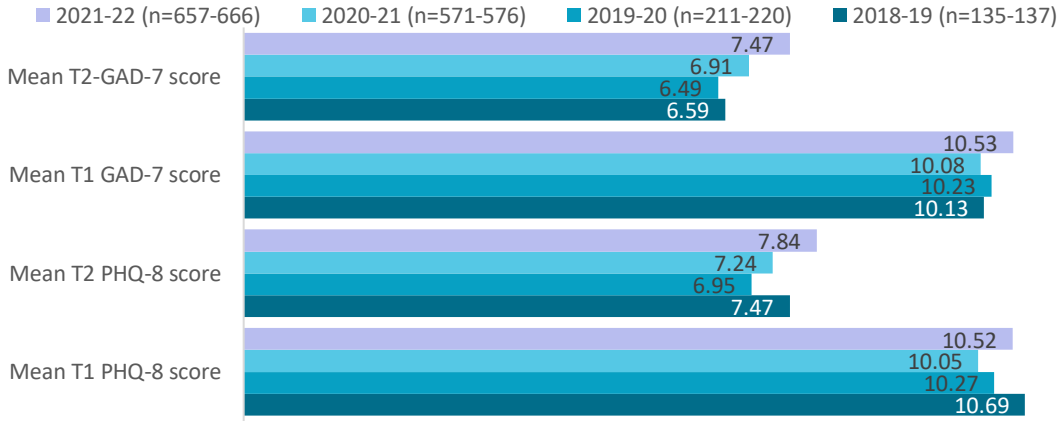
Figure 37. Patient attendance of CBT Skills Foundations has remained comparable to prior years



Improvements in both PHQ-8 and GAD-7 scores has also remained consistent over the past four years (Figure 38).

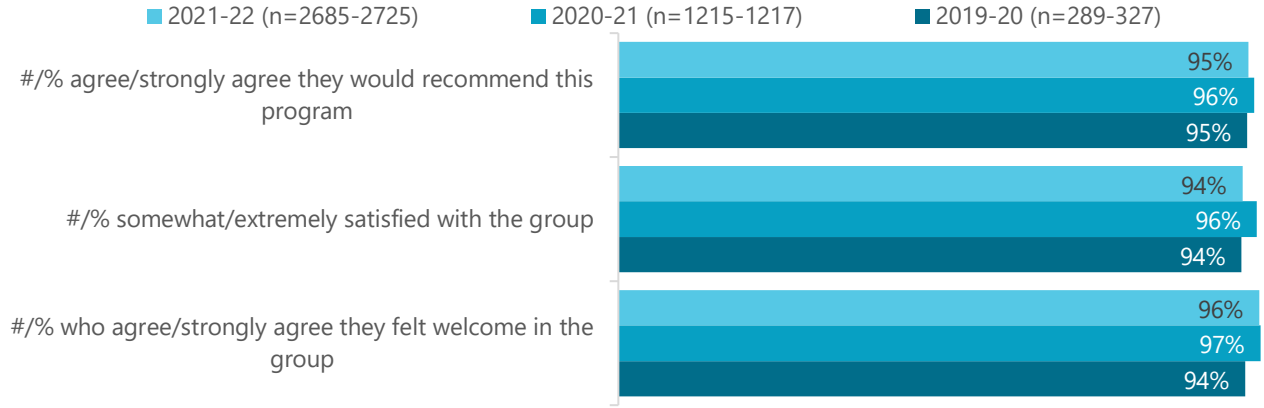
[24] *Figure 36 is based PHQ-8 and GAD-7 scores reported by the facilitator at the end of each group; only cases where a pre and post program score was reported by the facilitator are included in the analysis. Data will not match Figure 27 which is based on all available patient participant PHQ-8 and GAD-7 scores*

Figure 38. Improvements in patient PHQ-8 and GAD-7 scores have remained consistent



Lastly, **patient satisfaction with the program has also continued to be high, at 94% or higher** (Figure 39).

Figure 39. Patients continue to be satisfied with the groups and feel welcome



What, if anything, has facilitated the initiative's success(es)?

Key informant interviewees were asked to reflect on what has facilitated the success(es) of the initiative to date. The findings are identified in the table below.

Facilitator	Description
Building relationships with implementation partners	Consistent meetings and taking time to build relationships with the implementation partners was noted as a facilitator to the success of the spread initiative. One interviewee mentioned it was challenging to get to know the partners at first, however, said that the consistent meetings allowed for communication between partners and to pilot solutions to see what would work for everybody. They said, "It gave space for everybody to acknowledge any challenges they were coming up against to see if they could share the load a bit when things were a bit heavy."
Building relationships with external partners	One interviewee noted that a strength was leveraging existing relationships with Divisions of Family Practice in certain regions as well as health authorities to target physicians to become trainers.

Having the Skills Society operate as an independent organization	The independence of the Skills Society was a strength as the Society can operate free of any historical impacts or tensions that might arise if the program were to be held within another organization (e.g., health authority). Further, as an independent organization, the Skills Society can manage one central referral system and database for anyone across the province. One interviewee noted 'The family physicians love that [the central referral system]'.
Delivering Phase 1 training through UBC CPD	Through interviews, it was noted that partnering with UBC CPD was a strength for promoting and delivering Phase 1 training as word could get out through avenues such as UBC CPD's email blast, website, and eLearning site. One interviewee mentioned that UBC CPD has strong administrative support and are unbiased and well respected which allows them to work with top medical advisors and educational design specialists to design and deliver a program that meets the needs of physicians. As shared by a referring provider interviewee, having a provider participate in a group is great way to promote patient referrals. As shared by this referring provider, 'Ultimately the best thing is for a physician to participate in the group - for them to understand what their patient would experience as well. That's the best promotion you can do because you're then connecting the material.'
Dedication, passion, and strong physician leadership	Dedication and passion for the project facilitated physicians' promotion of the initiative and ability to demonstrate the impact to other physicians and psychiatrists. Interviewees mentioned that there was an overall belief in the project and sense of ownership amongst family physicians. One interviewee noted 'The program undoubtedly has been successful because of how passionate all the doctors who are involved are' while another mentioned the high commitment from family physician trainees and noted that in some cases, physicians had locums take over their practice so that they can train to become facilitators. As shared by one CBT Advisory Committee interviewee, "*Everybody has this overwhelming belief in the good of the project and the need for that. People are so dedicated about making this happen. We really believe in the why. It's really wonderful to have the same values and same goals. Every single person on the team is fantastic and very driven to deliver this service.*"
Offering CBT Skills Groups virtually	**Allowed the CBT Skills Groups to be scaled up more quickly:** In implementation interviews, one interviewee noted that the virtual groups allowed for the CBT Skills Groups to be scaled up at a faster rate. Most notably, virtual groups allowed for referrals from other regions of BC without having to worry about having a facilitator physically available in the region. One interviewee also commented on the administrative benefit of virtual groups saying, 'The administration of the program is more scalable because you don't physically need to be there to do all the stuff that was being done pre-online', tasks which included printing out and distributing resources to facilitators and scheduling physical spaces to hold the sessions in.

Able to reach and train more physicians to become facilitators: In implementation interviews, one interviewee mentioned that a previous barrier to spreading the initiative had been training family physicians to become facilitators noting, 'How do you train a family physician who doesn't have a psychiatrist in their community, physically there'. The interviewee commented that virtual groups have allowed psychiatrists from Victoria, South Island and Vancouver regions to reach and train family physicians across BC to become facilitators.

What, if any, challenges has the initiative faced?

The following table highlights some of the challenges highlighted by key informant interviewees:

Challenge	Description	Strategies used to address
Delayed development of foundational documents / identifying implementation partners' roles	• Interviewees mentioned that the delay in developing foundational documents such as the initiative management plan, communications plan, and partner engagement plan impacted how the partners worked together as there was a lack of clarity around the scope of the role of partners, how partners would work together, and what the leadership would look like. One interviewee noted that adjustments have been made and overall, partners are working well together, however, there are still instances of uncertainty around how partners are to work together.	• Bringing clarity to how partners would work together by developing the initiative management plan, communications plan partner engagement plan even after the initiative had been developed and implementation had been underway
Identifying, connecting with, and developing relationships with key partners (e.g., Ministry, PCNs, Divisions, health authorities)	• Implementation interviewees mentioned that the process of identifying, reaching out, and developing strategic partnerships with the Ministry, PCNs, Divisions, and health authorities was challenging, noting that it would be helpful to know the names of contacts at the health authority, for example. They also mentioned that a 'warm hand off' approach would be beneficial to help begin building relationships with partners who are key for the CBT Skills Groups' sustainability.	• Developing the communications plan, including identifying key people to engage with • Connecting with a consultant who was familiar with the health care system in BC and who could help to identify and facilitate introductions to get the CBT Skills Groups initiative on people's radar
Delayed development of Advisory Committee	• The Advisory Committee was developed after the initiative had already been underway and the CBT	• Adjusting the role and function of the Advisory Committee as needed

Skills Groups had already begun. One interviewee noted that as a result of the delay, it was challenging to leverage the expertise of the Advisory Committee members.

What, if any, external factors have impacted the initiative?

Key informant interviewees highlighted that the initiative is taking place amidst a crisis in primary care. Across the province many patients do not have a most responsible provider, or a provider they are 'attached' to, and struggle to access the primary care they need. Primary care providers are experiencing dissatisfaction with the health care system, and in some cases burnout due to this high need and demand for primary care. The COVID-19 pandemic continues to add extra layers of complexity.

Key informant interviewees have also perceived concern **from certain groups** about the CBT Skills Groups program **impacting family physicians' ability to focus on longitudinal family practice.** One interviewee noted that while it is uncertain if this perceived concern is having an impact on physicians' ability to focus on their practices, but there is concern around how this might impact the willingness of physicians to become trained facilitators.

To what extent can the outcomes of the provincial spread be sustained?

Considerations for further integration in the health system

Expanding diversity and reach: One interviewee noted that continued work around equity, diversity and inclusion is essential to sustain the program in 2025, with a focus on offering diverse groups with diverse facilitators, expanding reach to rural areas, and working with physicians and partners to create Indigenous-specific groups and indigenize the program.

> "Right now, what needs to sustain the program for a 2025 post-funding experience, **we need to have diverse groups. Diverse facilitators**."
>
> - *CBT Advisory Committee Interviewee*

Ensuring patients are a good fit for the program and that primary care providers understand referral criteria (e.g., mild to moderate mental health needs): Interviewees noted the importance of physicians appropriately referring patients to the CBT Skills Groups, noting a potential risk to the quality of the groups and the fact that an inappropriate referral could not be helpful, and potentially harmful, for the person who was referred. One interviewee mentioned that interactive and engaging resources were created to help educate physicians around the program.

Acknowledge that a high numbers of patients without a regular health care provider in BC: One interviewee noted that approximately 1 in 5 people in BC do not have a regular health care provider making it challenging for patients to be accepted into the CBT Skills Group program given that admittance into the program relies on a referral from a family physician or nurse practitioner.

> "We're realizing that the **number of unattached patients in the system is making it difficult for them to navigate being accepted in our system**."
>
> - *CBT Advisory Committee Interviewee*

Ensuring patients have access to local mental health support: One interviewee noted an unexpected challenge that arose with the spread of the virtual groups was ensuring patients have access to local mental health support, such as a physician, if they destabilize. The interviewee noted that currently, family physicians were providing the support, however, as the initiative continues to spread, it may be an issue as 1 in 5 British Columbians do not have a regular health care provider.

Building enough capacity to meet demand: One interviewee mentioned a future challenge is ensuring there are enough facilitators to meet demand, noting 'It's a long process to train facilitators. So, we need to build in that capacity with trained facilitators while at the same time boosting up the promotion but not too much'.

What is needed to sustain the program long term

Having a plan for long-term sustainability: Key informant interviewees identified that an important aspect of sustaining the program long-term is having a plan for how the program will continue once the Shared Care funding is over, noting that the ambiguity around long-term sustainability is a risk to the initiative. They also mentioned integration of the CBT Skills Groups into a provincial service map could be beneficial and mentioned that while work is being done around creating a plan for sustainability, there is currently little commitment from external organizations about the program. Two interviewees mentioned that health authority partnerships are key for long-term sustainability, however, concrete partnerships with health authorities are still theoretical.

Continued engagement and funding from partners: Key informant interviewees most noted that continued engagements with partners such as the Ministry of Health, Divisions of Family Practice, PCNs, health authorities, GPSC, and PHSA is needed to sustain the program long term. One key informant interviewee noted that establishing relationships and an awareness of CBT Skills Groups are essential to receive the funding that is needed to sustain the program long term. Another key informant interviewee further noted that partnerships with health authorities and Divisions would be beneficial in helping to secure physical space to hold the sessions once CBT Skills Groups begins offering in-person sessions again.

Discussion

Lessons learned from Year 1

Overall, the initiative is meeting its goals and objectives of 1) **improving physician wellness** through CBT training; 2) **training physicians to deliver CBT** to patients in group settings and 3) **increasing patient**

access to CBT-informed treatment. And it is doing so with continued adherence to key program fidelity and integrity indicators.

Successes from Year 1

The success of the spread initiative thus far is evidenced through of the cumulation of the various sources of evaluation data collected thus far, including program participation numbers, feedback and outcomes from program participants (physicians and patients) and trainees, as well as feedback provided by other stakeholders and those working as part of the spread initiative.

High uptake of / interest in Physician Wellness / Phase 1 training

For example, the initiative has seen high levels of participation from physicians in the Phase 1/Physician Wellness programs – 248 have participated (with an original target of 240) with relatively equal representation across all health authorities – demonstrating that the demand is high for a program that can support physicians' wellness needs. It may be that this demand will continue to increase in the next year of the initiative, as the current crisis in the healthcare workforce only seems to be increasing in seriousness.

Positive outcomes for family physician trainees

Outcomes and satisfaction levels of family physician trainees are equally encouraging, as physicians saw improvements in professional fulfilment scores, and corresponding decreases in work exhaustion and interpersonal disengagement scores from pre to post program. Also, physicians who participated in the Phase 1/Physician Wellness training were motivated to continue to learn about CBT and mental health management and planned to recommend the program to both patients and colleagues.

Maintaining program integrity

For the spread of the patient CBT Skills Foundations groups, encouraging growth is also being observed in the increase in total participant numbers, in the number of referring providers, and in the various health authorities and divisions of family practice with which they are affiliated. Given the growth and momentum observed at this report's interim stage, it is expected that these trends will continue through the second year of the initiative. Patient health outcomes and satisfaction are also strong – and in line with previous years, suggesting that a high level of fidelity and quality of the CBT Skills program has been maintained through the first full year of spread initiative.

Increasing program capacity

Capacity for offering CBT Skills Group programs also continues to increase, as the number of trainees has doubled since last year. While the 37 new trainees (those in phases 2-4 of training) trained in this first year of the spread initiative is still not near the initiative's total goal of training 100 trainees to become CBT Skills Groups facilitators, it demonstrates notable progress towards this goal.

Feedback from Phase 2-4 trainees is also highly positive, with trainees indicating that the training equipped them with the skills they needed to become CBT Skills Groups facilitators, energized them in their work and made them feel more connected to colleagues.

Addressing gaps in the health system

Finally, feedback from referring providers and other key informants suggests that the CBT Skills Groups Spread initiative is meeting an important need in the health system. For example, primary care providers indicate that patients whom they have referred to CBT Skills Foundations groups show a decrease in urgency and frequency of mental health visits (and in some case physical health visits as well), that they see improvements in their patients, that the program reduces the need to refer to Health Authority mental health services, and that the program provides overall more timely and affordable access to mental health care for patients.

Priorities for Year 2

As the initiative moves into Year 2, these positive interim results are encouraging. They demonstrate that the initiative is on track to successfully accomplishing its key goals and objectives. A priority for Year 2 of the initiative may be to continue to focus on embedding equity, diversity and inclusion as part of the program curriculum and delivery, as interim results suggested that while most participants across all identity groups feel safe and welcomed in the CBT Skills Groups, some participants noted additional suggestions for improvements in this area.

Continuing to focus on building the capacity infrastructure to train sufficient CBT Skills Groups facilitators – and build a strategy to ensure the long term sustainability of the program more broadly – are also likely to be ongoing, and important, considerations for Year 2.

Conclusion

Overall, the CBT Skills Groups Spread initiative is successfully meeting its goals and objectives of 1) improving physician wellness through CBT training; 2) training physicians to deliver CBT to patients in group settings and 3) increasing patient access to CBT-informed treatment. And it is doing so with continued positive results regarding program outcomes and satisfaction levels.

In addition to maintaining this current momentum and high level of program quality, an interest for Year 2 of the initiative may be to enhance focus on embedding equity, diversity and inclusion into the CBT Skills Groups program and facilitator training program, as interim results suggested that while most participants across all identity groups feel safe and welcomed in the CBT Skills Groups, there is still some room for improvement in this area.

Also, given the strong endorsement of the CBT Skills Groups initiative by physicians, primary care providers, patients and other stakeholders as having important benefits not only for individual providers and patients, but also to the healthcare system, building a strategy to ensure the long-term sustainability of the program more broadly is an important consideration for Year 2.

Appendix A: CBT Skills Groups Key Performance Indicators

CBT Skills Groups - Key Performance Indicator Dashboard

		Oct 1, 2018 to Sept 30, 2019			Oct 1, 2019 to Sept 30, 2020			Oct 1, 2020 to Sept 30, 2021			Oct 1, 2021 to Sept 30, 2022		
	Indicator	**% or N**	**Num.**	**Den.**	**% or N**	**Num.**	**Den.**	**% or N**	**Num.**	**Den.**	**% or N**	**Num.**	**Den.**
Phase 1 Trainees / Physician Wellness	# of primary care providers in Phase 1 / Physician Wellness training	**5**			**52**			**76**			**248**		
	#/% who agree/strongly agree they can communicate / explain value of CBT to patients	No data			**100%**	12	12	**100%**	28	28	**93%**	127	136
	#/% who agree/strongly agree they will use CBT skills in their professional life / in their own practice	No data			**100%**	12	12	**100%**	28	28	**66%**	89	134
	#/% who agree/strongly agree they will recommend the program to colleagues	No data			**100%**	12	12	**100%**	28	28	**95%**	129	136
Phase 2-4 Trainees	# of primary care providers in Phase 2 training	**2**			**8**			**12**			**24**		
	# of primary care providers in Phase 3 training	**2**			**7**			**3**			**7**		
	# of primary care providers in Phase 4 training	**2**			**8**			**8**			**6**		
	#/% who agree/strongly agree CBT skills training is making a difference for patients	No data			No data			**100%**	8	8	**100%**	6	6
	#/% who agree/strongly agree they would recommend the training program	No data			No data			**100%**	8	8	**100%**	14	14
	Average change in patient PHQ-8 pre/post score reported by facilitators	**-3.11**		244	**-2.91**		338	**-3.79**		824	**-2.89**		1168
	Average change in patient GAD-7 pre/post score reported by facilitators	**-3.86**		244	**-3.29**		338	**-3.80**		824	**-3.11**		1168
	#/% of patients who agree/strongly agree the facilitator was effective at leading the group	No data			Insufficient data			Insufficient data			**96%**	1439	1502
Referrals	# of patients referred to the CBT Skills Groups program	**2336**			**2678**			**4303**			**5882**		
	Average PHQ-9 score at time of referral	**11**		2303	**11**		2633	**11**		4122	**11**		5735
	#/% of referred patients refused due to unsuitability (any reason EXCEPT incomplete form)	No data			No data			**7%**	318	4303	**6%**	362	5882
	Average # of patients referred per primary care provider	**4**		555	**4**		643	**4**		1031	**4**		1486
	Range # of patients referred per primary care provider	Max 57; Min 1			Max 39; Min 1			Max 60; Min 1			Max 67; Min 1		
	Mode # of patients referred per primary care provider	**1**			**1**			**1**			**1**		
Patients	#/% of registered patients who completed CBT Skills Foundation training (6 or more sessions)	**78%**	492	631	**70%**	738	1061	**77%**	1056	1373	**77%**	1516	1963
	#/% of registered patients who partially completed CBT Skills Foundation training (1 to 5 sessions)	**19%**	117	631	**26%**	273	1061	**19%**	265	1373	**20%**	385	1963
	#/% of registered patients who were no shows (did not attend any sessions)	**3%**	22	631	**5%**	50	1061	**4%**	52	1373	**3%**	62	1963
	Mean T1 PHQ-8 score (only of those with T1/T2 available)	**10.69**		137	**10.27**		220	**10.05**		571	**10.52**		657
	Mean T2 PHQ-8 score (only of those with T1/T2 available)	**7.47**		137	**6.95**		220	**7.24**		571	**7.84**		657
	Mean T1 GAD-7 score (only of those with T1/T2 available)	**10.13**		135	**10.23**		211	**10.08**		576	**10.53**		666
	Mean T2-GAD-7 score (only of those with T1/T2 available)	**6.59**		135	**6.49**		211	**6.91**		576	**7.47**		666
	#/% who agree/strongly agree the CBT Skills program improved their ability to self-manage their condition / ability to manage	No data			**83%**	289	348	**85%**	1039	1216	**88%**	2353	2685
	#/% who agree/strongly agree they felt welcome in the group	No data			**94%**	325	345	**97%**	1174	1216	**96%**	2621	2720
	#/% somewhat/extremely satisfied with the group	No data			**94%**	325	347	**96%**	1166	1215	**94%**	2529	2696
	#/% somewhat/extremely satisfied with the ability to start the CBT Skills Group when you wanted to	No data			No data			No data			**86%**	1043	1215
	#/% agree/strongly agree they would recommend this program	No data			**95%**	327	346	**96%**	1163	1217	**95%**	2582	2725
Program Capacity	# of active certified facilitators	**17**			**18**			**23**			**33**		
	# of Level 1 groups	**133**			**129**			**156**			**246**		
	# of groups facilitated annually per facilitator (total groups divided by total # of active facilitators)	**8**	133	17	**7**	129	18	**7**	156	23	**7**	246	33