Developing European models of training in C-L Psychiatry and Psychosomatics

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on behalf of the EACLPP Workgroup on Training

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Aims of the workgroup

Enhance development and evaluation of

- models for training psychiatric residents in C-L psychiatry and psychosomatics
- models for advanced (specialist) training in C-L psychiatry and psychosomatics
- models for teaching psychiatry and psychosomatics to medical students, physicians, and nurses

Proceeding in consensus on standards of training, establishing national and European guidelines

Activities of the workgroup

1st Meeting in Oslo 2000

- models for teaching psychiatry and psychosomatics to primary care physicians

2nd Meeting in Leiden 2001

- consensus meeting on specialist training

Both meetings showed wide diversity between training programs throughout Europe

Survey among experts in 16 European countries

3rd Meeting in Lisbon 2002

- consensus meeting on basic training for residents
- ongoing consensus process
- first steps towards European guidelines

4th Meeting in Zaragoza 2003

- Guidelines on training for residents

Basic training in C-L for residents: Status quo

Rotation to C-L service:

- ***mandatory:*** Portugal (3mo FT, year3-4), Spain (4mo FT)
- ***recommended:*** Netherlands (6mo FT), Norway (6mo FT), U.K. (6mo FT in specialist training), Germany-PSO (3-6mo HT)

Rotation to General Medicine:

- **Internal Medicine:** Austria, Germany-PSO, Norway (1 yr)
- **Neurology:** Austria (1 yr)

Supervised consultations:

- Germany (20), Italy (25)

Seminars/case-conferences:

- 10-128 hours

Formal national guidelines:

- **Netherlands** *(Sno HN, deBoer WRN. Nederlands Tijdschrift voor Psychiatrie 1994;36:597-603)*
- **United Kingdom** incl. assessment of competency *(Guidelines for Teaching Liaison Psychiatry. Bull R Coll Psychiatry 1988;12:389-90)*
- **Germany-PSO** incl. formal examination *(Herzog T, Stein B, Söllner W, Franz M: Schattauer 2002; (www.uni-duesseldorf.de/awmf/)*
- **Spain** *(Lozano Suarez M et al. Guia docente en psychiatria de enlace. Actas Esp Psiqiatr 28(6):394-398)*

Problems

- Lack of clear objectives and lack of guidelines
- Very heterogeneous quality of teaching programs
- Lack of well structured C-L units which can provide training
- Lack of full-time senior C-L psychiatrists who can teach/supervise trainees
- Lack of clear requirements for teachers
- Lack of training posts for rotation to C-L units
- Rotation inside the C-L unit is problematic (continuity of care)
- What is the role of experienced C-L nurses ad psychologists in training programs?
- Who is paying the costs?

Consensus on basic training for residents: Organisation

- Training must be included in the curriculum of education in general psychiatry. Residents have heavy work-load. Thus training in C-L must be **feasible**.
- In any case, **full-time** training is an advantage. It better allows continuity of care. If training is part-time the kind and amount of other tasks of the trainee should be clearly defined.
- A minimum of **6 months** full-time rotation to a C-L department should take place in in the **second part of residency**: trainees have basic knowledge and skills in general psychiatry and, therefore, can be better integrated in C-L work.
- Training **Supervision of trainees** should be clearly defined and organised: Who is the supervisor? Frequency and amount of supervision; individual or group supervision.
- The **ratio between regular C-L team members and trainees** should be fixed.
- Residents should acquire **basic expertise in general medicine** in order to gain clinical understanding of physical disorders and their relation to abnormal illness behaviour (no consensus about how to organise this)

Consensus on basic training for residents: Knowledge

Theoretical psycho-somatic foundation

- Bio-psycho-social model
- Psychophysiology, PNI

Ethical and medico-legal issues (relevant to particular country)

Understanding the **consultant's role**

Assessment and management of

- Delirium/dementia (13/16; 1-10h)
- Somatisation (13/16; 2-6h)
- Depression and anxiety in the somatically ill (12/16; 2-20h)
- Suicide/self-harm (11/16; 2-8h)
- Addiction problems in the medical setting (6/16; 2-8h)
- Abnormal illness behaviour in the somatically ill (8/16; 2-20h)
- Chronic pain
- Gender-specific disorders incl. sexual dysfunction
- *(Child & adolescent disorders)*

Consensus on basic training for residents: Communication and diagnostic skills

Basic communication skills:

- Understanding referral
- formulation of goals of intervention
- Interview with the medically ill and his/her loved ones (use of facilitation techniques, responsiveness to emotions etc.)
- Educate pts about disorder and treatment
- Communication with the dying patient
- Management of non-compliance

Diagnostic & formulation skills:

- Report findings of history
- Organic formulation
- Psychological/psychodynamic formulation
- Social/environmental formulation
- Individual and social strenghts
- Cognitive testing
- Differential diagnosis
- ICD-diagnosis
- Basic documentation

Consensus on basic training for residents: Treatment skills

Specific interventions with patient:

- Bio-psycho-social treatment plan
- Psychopharmacology in the medically ill (12/16; 1-6h)
- Crisis intervention, relaxation and psychotherapeutic techniques with the medically ill (10/16; wide range of hours)

Interventions with HC teams:

- Quality of written records
- Quality of personal communication
- Liaison issues management: case-conferences, ward rounds etc. (7/16; 2-10h)
- Co-ordination of care for the complex patient (networking)

Special training/Fellowship in C-L

Status quo:

- **Finland:** 2-years training in „special competence" of GH Psychiatry
- **Germany:** Fellowship in Psychosomatic/Psychotherapeutic Medicine (4-years training)
- **U.K.:** Special endorsement in C-L Psychiatry as part of specialist training: at least 1 out of 3 years fulltime at C-L unit

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Consensus: Contents additional to basic training

Attitudes: visions, identity

Knowledge and skills:

- Intensifying knowledge and skills in general contents
- Special psychosomatic topics in cardiology, oncology, chronic pain, gynecology, geriatrics, pediatrics, AIDS, ICU, Tx etc.
- The complex patient: assessment, co-ordination of care
- Psychotherapy: focused methods, disorder specific (CBT, expressive-supportive, group approach)
- Liaison: communication in HC teams, group dynamics
- Ethical issues: ethical dilemma
- Management/organisational skills: how to run a C-L service; major incident planning
- Research in C-L (methodology)
- Teaching C-L (becoming a tutor)

Consensus on didactics

Didactics

Seminars and case-conferences: local, interdisciplinary, including medical staff, nurses (example: Modena)

Journal clubs (Psychosomatics, Gen Hosp Psych, J Psychosom Res) and study of literature (Textbooks)

Tutorial and supervision: accompany permanent C-L staff, informal meetings and communication, direct and indirect SV (internal and external) by experienced C-L staff (faculty) (example: Nuremberg)

Intensive courses: centers of excellence (example: Manchester)

Follow-up/refreshment courses

Assessment of competency and efficacy

(Up till now no consensus)

- Feedback of tutors (checklist)
- Minimum number of supervised consultations
- Assessment based upon clinical supervision
- Examination (for higher training)?
- Competency measures should be developped
- Residents should also evaluate supervisors

Example for case-seminars: Modena

Structure and organisation:

- **weekly** clinical case-conference, 90 minutes, 15-20 participants
- presentation of case by the **resident**
- invitation of the **medical staff** who have in charge the patient (PCP, GH ward staff, social worker...)
- discussion of case in **interdisciplinary round**
- conducted by the **full-time C-L faculty** psychiatrist and a psychology researcher
- **open** to psychiatrists, residents from other wards, nurses, medical students, psychiatric rehabilitation students

Experiences:

- **positive:**
  - a regular, weekly, dedicated moment where to stop and think of what is done and how
  - easy, informal discussion, open to all members in a non-hierarchical way
  - focus on trans-disciplinary relational patterns and abilities
- **negative:**
  - not easy involvement of other medical members (exp. physicians, often too busy or not interested)

Publication: Rigatelli et al. (2000) Psychother Psychosom 69:221-228

Example for tutorial and supervision: Nuremberg

Structure and organisation:

- Each resident or host is designated to a full-time C-L specialist (**tutor**)
- **Accompanies** C-L specialist to consultation and liaison activities during a period of some weeks
- **Conducts consultations** himself/herself under daily supervision and informal discussion about cases and HC team communication with the specialist
- After some weeks resident is designated to another specialist working within **another medical field**
- **Direct supervision** of consultations by C-L specialist
- **Indirect supervision** in small groups twice a week (90 min); led by head of the C-L service and/or head of the department; focused on case and dynamics of the system
- Supervison led by **external supervisor** bi-monthly (90 min) focused on dynamics of C-L team

Experiences:

- **positive:** intensive learning and personal communication; possibility to reflect own problems and counter-transference
- **negative:** time-consuming**,** no formal training of tutors

Example of an intensive course: Manchester, UK

Structure:

- 1-week course twice a year.
- Limited size (<24 participants)
- Emphasis on small group work/ serice developments/ cases

Contents:

- Deliberate self harm services
- Medico-legal aspects
- Accident & Emergency
- Managing Somatisation
- Reactions to physical illness
- Developing research proposal

Experiences:

Positive : small group work / hard & challenging

- exposure to national experts
- emphasis on service development
- most UK C-L psychiatrists have attended + other Europeans

Negative: no Child & Adol/ Old Age Psych. very little

- critical feedback!

Organised by Elsbeth Guthrie & Francis Creed

Future perspectives

- European guidelines
- Recognition of C-L units who are allowed to organise training
- Guidelines and training for teachers
- Rotation for all residents/ C-L posts for training
- Training program for C-L nurses
- Training programs for primary care physicians and nurses
- European School of C-L Psychiatry and Psychosomatics